The Pre-School Child

By G. A. LAMONT, M.D., F.A.C.P.

If we really want to be honest with ourselves, then I think we will readily admit that the subject for this period, instead of being "The Pre-School Child" would more appropriately be called "The Neglected Child." I will not enlarge further on this, but in contrast, please think of the ever present Well Baby Clinics and the established system of school health inspection. In some districts of British Columbia an effort has been made to make up for this neglect, but generally speaking the very important phase in a child's life from 2 to 6 years receives little or no attention. It behooves you to further the interest in this age-period by organised methods, and by your personal influence in the individual families with whom you are daily coming in contact. It is not my intention to deal with numerous physical defects and their relation to the condition of these children, for after all outside of physicians, where does one find a keener appreciation of the necessity of correction of physical defects in children than in a group of public health nurses. I purpose drawing your attention to some of the outstanding features I have to deal with in my practice with this early age group of children. All of us are easily led into well-fashioned grooves and inclined to carry on our work in a stereotyped fashion and it is therefore good for us at times to inquire into our mode of procedure, into our set ideas and our stock phrases as to whether we aren't hanging our methods and ideas on a lighthouse upon which the waves of changing ideas and advancement have made inroads. Thus, from the standpoint of practical application, our work is made less effective when the application of common sense is brought to bear upon the subject.

We have with us too much mal-nutrition. Do not misinterpret me here, I mean we have from our statistics more mal-nutrition than actually exists in any given group. The reason for this is the lack of appreciation of the difference between the underweight child and the mal-nourished child and a failure to properly realise what is meant by mal-nutrition. The bug-a-boo of underweight, is fast giving way to a saner view of Nature's laws and the fundamental rules of heredity are receiving more consideration. In the world of stock, whether it be race horses or prize puppy dogs, every consideration is given to the parental stock in breeding, yet when we come to the human family it seems that we wish to ignore these fundamental principles and expect a child of a slim parentage to measure up and be compared with that of a child whose stock is of entirely different build. We all of us in our work desire to act on a practical basis, yet I do not know of any more glaring instance of the lack of its application than in this particular problem. The attitude which one must have in regard to height and weight tables, no matter which variety is used for they are all more or less the same, is that from the practical standpoint they should be considered only as a guide. It is the difference from month to month that is of importance, bearing in mind also the marked difference in seasonal gain. If over a period of several months a child does not gain or actually loses, he should then be considered pathological. What I mean is that too often the height and weight records are being used as a basis for mal-nutrition and as I previously remarked a proper

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sense of appreciation of what constitutes mal-nutrition must be obtained first. Take a little laddie whose posture is good, whose facial expression is happy with bright keen eyes, whose mucous membranes are of good colour, muscles firm, and in fact one might say of such a child, that "his skin fits him." Such a youngster, be he 15 per cent. or so underweight causes me no worry whatsoever, yet repeatedly I find parents greatly alarmed over this. The idea of underweight permeates the home through reports from older school children and from endless magazine articles and papers of the present day.

What we need to worry about is not this type of child, but the one who is suffering from real mal-nutrition. In this type of child you generally have poor posture, drooping forward of the head, and rounding of the shoulders, flattening of the chest, protrusion of the abdomen, circles under his eyes, muscles flabby and "his skin does not fit him." One may often have, and in the majority of the cases does have, the question of underweight also, but do study your child first of all without the scales and height rule and then bring these measurements into play to help complete your picture. Having said all this do not think for a minute that I am trying to belittle the effort which undoubtedly all of you are making in regard to the under-nourished child, for by such work you have accomplished a great deal of good in your districts and communities. You have made the people take a greater interest in the health of the youngsters, but from your own standpoint on this subject, try to get the broader outlook. Before leaving this, there is one more thing to which I want to draw your attention, that physical defects do not necessarily bear a relation to the state of nutrition. The term "Free to Gain," if related to physical defects is misleading, a great emphasis has been placed on the necessity of correcting a child's physical defects to prepare him for a gain in weight. Recently, a group of children of over a thousand were carefully studied and it was definitely shown that the group which, on account of their physical defects having been corrected and were considered as free to gain, didn't fare any better than the control group who were left untouched, in fact t h e s e last ones showed up a bit better. This does in no way mitigate against the importance of correcting physical defects, because there were a number of striking instances in which a rapid and persistent gain followed the correction of a defect. It does mean, however, that some physical defects are in no way related to the state of nutrition. This is one example that I had reference to a little while back when I said that we should consider our stereotyped phrases in regard to our work.

Now, let us consider some outstanding features in the child's diet. I am not going to launch out on the wide open sea of scientific diets, rippled with practical and theoretical ideas of vitamins, etc., for I think we are all familiar enough with this subject, that we can steer our craft, be it laden with green vegetables or coffee and jam through to the safe port of proper vitamins and balanced diets. I have just used the word "outstanding features" of these children's diets, it would have been more accurate to use the word "feature," for after all to me there is only one outstanding trouble and that is these children from two to six get too much CHO. Just stop and think for yourselves of the average diet of such a child and notice the prominence of starchy food. He starts off with an excessive amount of cereal, helped along by a lot of milk, during the morning a piece of bread and jam and more milk increases the amount, and at noon-time a large serving of potato and an excessive amount of bread helps along the total. A biscuit or cake during the

afternoon makes the total bigger and better, while the evening meal with the often predominating cereal supper dish with more bread and some cake, makes a fine finish to a starchy day.

I am not going into the caloric value of these meals nor a detailed consideration of the proper ratio of the food elements, but just in general I mention that after all, these children require a liberal amount of protein for waste and growth and a reasonable amount of CHO for their activities, while the adult requires an amount of protein for waste and a liberal amount of CHO for his activities. It is rarely that I have not to markedly lessen the CHO for these little folks. Cut down the cereal in the morning and make room for an egg or bacon and if necessary, temporarily discontinue the cereal until a desire is created for these other breakfast dishes. Giving the child less bread and jam and milk during the morning benefits it, in fact such a mid-morning lunch should be eliminated and an appetite left for a wholesome meal at noon. Just here if I may wander a little from my subject, I think the indiscriminate taking of milk at recess time at schools should be carefully inquired into and selected cases only considered. As for the little folks, at noon time lessen the potato, eliminate the bread and let the cereal puddings not take too prominent a place on the menu and the same may be applied to the evening meal. Now just a word as to bread: to begin with, it is not a complete food. It contains too much CHO. A proper diet should have the protein and CHO in the proportion of 1 to 4.2, and the fat to the carbohydrate as 1 to 6. In bread, however, the protein is 1 to 8.5 carbohydrate, and the fat negligible. Besides, we do not get full value for the protein ingested, since it is only utilised to about 50 per cent. compared with nearly 100 per cent. in beef. It is plain, therefore, that bread should only be used as part of a mixed diet.

The much debated question of brown bread versus white as an article of diet cannot be considered as finally settled. Various attempts have been made by food reformers backed by those interested financially to get people to use flour containing portions of offal, germ, etc., that is, the various brown breads, but the people on this continent and in the United Kingdom still prefer white bread and provided the diet is sufficiently varied, the question is not of much importance.

Brown bread has some advantages, which I may mention. Its content of fibre gives it more bulk, but less protein and carbohydrate nutriment than the same weight of white bread. The fibre is useful in combating constipation, though the effect is said to wear off in time. As a matter of fact, I find many times, children with obscure intestinal conditions which respond readily to the removal of whole wheat bread from their diet. The constant irritation to the intestinal mucosa sets up a state of mild chronic inflammation. One frequently finds this in a more marked state when certain well-known widely advertised products are used with the cereals. It contains a little more vitamin B (antineuritic) than white, and more mineral water. As, however, this last is largely excreted by the intestines, the excess may be left out of account. The protein especially, and also the carbohydrate in brown bread are not so easily digested as those in white bread, because the fibre seems to interfere with the digestive juices. The wise course is probably to include some proportion of whole-meal bread in a general diet.

Extra fat and protein should always be eaten with bread, and in this respect, the custom of drinking milk and eating butter and cheese with bread is sound, though of course in young children, discretion must be used.

From an economic point of view, bread must be considered one of the cheapest and best foods, for if its value be reckoned in calories, it easily heads the list. This very cheapness encourages too much reliance to be placed upon it, especially in the case of young children to the detriment of their health and growth.

There is one disease which I must mention and it is the only one I am speaking of, namely, rickets. In medicine, when we are interested in certain conditions we are on the lookout for them and so oftener find them. This, it seems to me to be the case with rachitic conditions, for I am meeting them more and more, varying from extreme cases approaching almost marked orthopedic defects to many minor bony changes, making one feel that such an opportunity as this should not be lost in gaining your interest. You can have such an effect in the first two years of life in the prevention of this constitutional disease. Cod liver oil in the dark months of the year and a liberal use of sunshine whenever available with a proper distribution of green vegetables are your safeguards. Do not feel yourself on safe ground just because the baby is breast fed, for the danger of rickets lurks here also.

Closely allied to this is another problem. For some reason people fail to realise that young children must have good teeth to masticate their food just the same as you and I. The story of the neglect of these first teeth is indeed a very old one. A great number of intestinal disturbances and allied states of malnutrition at this age are attributable to poor teeth. Many cases of general poor health are due to oral sepsis.

It is obvious that the best defence of the tooth lies in the laying down of a healthy enamel, and the use of the tooth brush and of antiseptic dentifrices can do nothing to produce healthy teeth, though they may help to preserve them when they are defective. The calcification of the teeth begins about the fifth month of intra-uterine life and at birth the cusp of first molars of the permanent set are already laid down. By the end of the first year, a considerable portion of the crowns of the permanent set are formed. A fact not sufficiently appreciated is that by the end of the fifth year, the greater part of the second dentition is already present in the child's jaw, in its permanent form which nothing can alter, long before any of these teeth are erupted. and therefore, before they can be mechanically affected by the food taken. This early calcification requires that healthy and generous diet should be prescribed for the mother for the preservation of the primary teeth and then later, for the continued development of sound teeth in the child, wholesome well-balanced food is as usual most essential. Lack of sunshine and of fresh air and of opportunity of exercise in the sunlight are the essential factors interfering with the proper distribution and utilisation of calcium throughout the body, in the bones and nervous system, as well as in the teeth.

Of all these conditions affecting the health of these little folks, there is one outstanding, and that is the lack of rest. This problem of the unrested or fatigued child is the commonest one we have to deal with. I do not refer to the fatigue that is due to the unfitness of the child on account of an illness or uncorrected physical defects nor to the fatigue due to a certain amount of play, but to the habitually unrested child. This generally shows itself by a feeling of fatigue, actual decrease in physical strength and endurance, lack of alertness and their emotions are easily unbalanced.

We are so accustomed to ascribe the ceaseless activity of children to what we term inexhaustible energy, that we fail to recognise the fact that many of them are, as a matter of fact, going through motions of childish play without natural, spon-

taneous enthusiasm. The normal child plays hard, rests well and awakens fresh, with others it is not so.

Moreover, human efficiency depends not only on the amount of energy available for production, but also upon its conservation. The inhibitory mechanism, which protects the human machine from useless waste of energy and unrestricted activity is not fully developed in the child as is attested by his impulsiveness and lack of deliberation before acting.

We must also consider the emotional reactions of the child. If the child were living in an atmosphere free from emotional stimulation, the problem of fatigue would be quite simple. But where is there a child today who is not exposed to emotional strain, fear, worry, anxiety, excitement and nervous tensions? He is more easily upset than an adult and incidents that are made light of by the adult often make a deep impression upon the youngster.

Why doesn't the child get sufficient rest in the first place? Well, the answer I generally receive is, "He won't go to sleep" and he won't do this and won't do that, and therein lies the trouble. There is something wrong in the home. It is the parents in the majority of cases, directly or indirectly, who are to blame and not the child for receiving insufficient rest—it's home control and management, and this condition one has to ferret out and it is almost real detective work to arrive at the source of the trouble.

Then we have the little tot, who "fights sleep" but why blame him? After a pleasant and perhaps boisterous session with mother, or especially father, it's no fun to be suddenly picked up and carried off to a dark and uninteresting bedroom and no wonder a resultant cry occurs. Too much excitement before bedtime is never allowable and if going to bed is made an interesting affair and turned into a game of sorts, thus directing the young mind, much is accomplished. No petting should be indulged in and it will gradually be born in on his mind that screaming won't purchase a reprieve.

Then there is the child who won't take his nap. Incidentally all children should have that mid-day nap. He has decided he is wasting time by sleeping in the day time. Whether sleep will come or not, a darkened room will help and possibly a little more muscular activity might be allowed!

Wakeful children and night terrors are often caused by a heavy or late meal, often too by some gruesome tale told by an adult, or a horror of some threat which has been held over them. That is, night terrors are as a rule determined by the suppressed fears of the waking hours.

May I here remark upon the fact that children need control. They need to feel a strong will directing, restraining and confining, limiting and steadying them. Only in this way can they acquire real strength of will and character as opposed to stubborness and strongheadedness.

The argumentative child is only too familiar, questioning everything that is asked, particularly as to why he should go to bed and at last succeeds through a prolonged conversation in deferring the bed hour. Unfortunately, parents often proudly think this is an exhibition of early reasoning power.

Being afraid of the dark is a not infrequent story. Through the carelessness of a parent or nurse it is very easy for a series of dreads to be established and everything possible should be done to avoid the suggestion to fear the dark.

As I have previously stated, the "Unrested Child" is one of the worst problems we have to deal with. Unrest really resolves itself into lack of sleep and quite irrespective of an especially planned day or properly arranged rest period, all of which play an important role, in the long run the average case comes down to

the simple solution of not in bed and asleep early enough. Invariably this reflects back on the question of bad handling on the part of the parents, frequently from the lack of home discipline and training. Here we approach very near to the heart of the subject. Stripped of all that is not essential, we see the problem of management of children reduced to the interplay between the adult mind and the mind of the receptive, suggestible child. That which is thought of and feared for the child, that he rapidly becomes. Placid, comfortable parents, who do not worry about their children, find their children sensible and easy to manage, while the apprehensive, nervous parents are forced to watch their child acquire a reputation for nervousness which, as always, is passively accepted and consistently acted up to by the child.

I have tried to give you a few ideas on the outstanding problems that I am constantly meeting amongst these little folks who spend the day at home, and who have not yet stepped out into the cold world. I feel that a proper appreciation of mal-nutrition and underweight will make one's work more effective. The outstanding error in the diet of these children is the excessive CHO intake. Rickets, with its aftermath in the pre-school child demands attention. Most important however of all, is the unrested and fatigued child and if there is one thing I hope may be remembered from these rambling remarks, is the old adage, "Early to bed, early to rise, makes a man healthy, wealthy and wise."

Adelaide Nutting and Lavinia Dock Prize

For an Historical Essay Dealing With a Nursing Subject

The History of Nursing Society, School for Graduate Nurses, McGill University, has received the following announcement and forwarded it for publication:

In honour of these two pioneer writers of Nursing History, a prize of one hundred dollars has been offered for the best historical essay submitted by a student or graduate nurse, before January 1st, 1931. The conditions are as follows:

1. The subject must be one which is directly concerned with some important phase of nursing history.
2. The essay must show original research by the writer.
3. The essay should cover from 8,000 to 10,000 words and should be type-written.
4. There should be a cover page with full title, a table of contents, and a brief outline of the subject-matter of the essay.
5. The essay should be fully documented with foot-notes and should contain a detailed bibliography.
6. The language used should be English, French or German.

Any student or graduate nurse wishing to enter the contest should write to the chairman of the History of Nursing Committee, Miss Nina Gage, 370 Seventh Avenue, New York City, giving her name, address, professional training, and experience, and two references. Each registered contestant will then receive a number which she will place on the essay instead of her name. Her name and number should be enclosed in a sealed envelope accompanying her paper, and the whole should be insured if sent by mail.

The judges will make their decision on the basis of:

1. The worth of the material.
2. The sources consulted.
3. The form of the paper.
4. The clarity and originality of the presentation.

Christmas Message from Mrs. Rebecca Strong

Christmas, 1929.

17 Woodburn Terrace,
Edinburgh.

My Dear Young Friends:

I am unable to thank you individually, but the Editor of your official organ, "The Canadian Nurse," has kindly allowed me to do so collectively.

I am deeply grateful to you for the very loving and touching manner in which you received me on all occasions while with you in Canada.

May I also offer you a word of encouragement. You are now starting on the same line of life on which it has been my happiness to travel, and can strongly recommend it to you as one full of joy, if followed in a true spirit of helpfulness. It is a path on which you will meet all phases of life. Allow no foolish prejudice of race, colour, creed or school to mar your usefulness. There is but one foundation for all good nursing, viz.—the spirit of loving helpfulness.

The technique to prepare you for your work is another matter. That must be acquired according to the needs of each country.

I think we have had the Armageddon, let us with one heart and mind work right loyally for the coming of the Millenium!

The establishing of peace and good-will on earth.

I wish you all a very happy Christmas, and a bright light to guide you through the coming days.

Very sincerely yours,

Rebecca Strong

Medical Aseptic Technique

By ELLA M. FORREST, Supervisor, Infectious Disease Department, Vancouver General Hospital

Medical aseptic technique works on the theory and principle that disease is transmitted by contact, not airborne, and in this respect it is interesting to note how far we have travelled since the time, not so very long ago, when in the event of an infectious disease such as diphtheria breaking out in a community the road was promptly barriered in order to prevent people being infected in driving past the house.

Even now we are frequently asked by patients or their friends: "How do you nurses keep from taking these diseases? I suppose you keep gargling your throats all the time." Great is their astonishment and incredulity when we assure them that our greatest safeguard is often and well-washed hands. The technique is simple, easily understood, reliable, and because of its absolute cleanliness, most satisfying to the heart of a well-trained nurse.

Then, since disease is transmitted by contact, direct or indirect, it is necessary to know what constitutes direct and indirect contacts. The former are usually evident, easily taught and understood, consisting, of course, in the actual touching of an infected patient or his fresh secretions. Not a great deal of danger exists in the direct contacts because, being obvious, they are usually promptly and properly cleaned up. It is in the indirect contact that the danger lies; this is the phase of the work that makes great demands upon our alertness and vigilance, and, of course, the greater part of our ward instruction comes in here, not only with the nurses, but with everyone who comes in contact with the patient: maids, orderlies, cleaners, and dare I whisper

it—sometimes our doctors. In teaching the pupil nurses, before defining an indirect contact, it is necessary to determine that they fully understand the significance of the word "contaminated," that anything that contains or may contain the organisms of disease is contaminated. This brings us back to an indirect contact, which is the touching of something that has been contaminated by the patient. For instance, a nurse wears a gown to prevent her uniform from coming in contact with the patient or any area contaminated by him, his table, chair, etc. When the gown is removed, it is folded once lengthwise, the two insides or clean sides together, thus when it is hung up, one contaminated side touches the wall, and the wall becomes an indirect contact.

Considerable thought is required on the part of individuals working with communicable diseases to watch the indirect contacts, and it is because of the indirect contact that so much thought is necessary in evolving a technique that will prevent the spread of a disease. This technique is just as exacting in the demands necessary to the fulfillment of its requirements as that of the operating room; in fact, both are based upon the same principle, the conditions under which the two work being reversed. In the operating room, the patient, surgeon, nurse and their equipment represent the clean area; in medical asepsis, the patient, the area surrounding the patient, and the nurse caring for the patient represent the contaminated or unclean area.

Everything outside the patient's room or areas is clean, with the exception of the sterilizers or utensils used in disinfecting contaminated articles. In going more closely into the details of technique and dealing more with facilities, it would perhaps be well to start with admission of patients.

We have our ambulance entrance, used only for admission of patients; our carriage is always in readiness with an extra sheet, in which to completely drape the patient, thus preventing all contact between the patient, and his possibly infected clothing, with our clean carriage. The sheet is left in the room with the patient, the clean carriage returned to the admitting department.

The patient is undressed, put to bed, all personal clothing enclosed in clean covers and sent to be sterilized. All patients are kept in separate rooms for eighteen days following admission: at the end of this period they may, if suffering from a common disease, be placed in larger or open wards. We have not yet had sufficient confidence in our technique to place different diseases in one open ward, although this method is successfully carried out in some hospitals for communicable diseases, with the exception perhaps of measles and chickenpox, which seem to defy at times even the separate room type of medical asepsis.

Equipment of Rooms.—Each room contains equipment for general bedside care of patient, all basins, utensils, etc., remaining in room until discharge, when everything is sterilized. In rooms not provided with lavatories, bedpans and urinals are sterilized each time after use, the covers being used only once.

Care of Patient's Clothing.—It is listed in the clothes book the same as on other wards, but in our case requires two nurses: one contaminated in handling clothing, one clean to enter in clothes book. Outside clothing is folded as smoothly as possible, enclosed in a clean sheet; other articles placed in clothes bag and sent to sterilizing room, the covering being necessary, of course, to prevent indirect contact of corridors and elevators used in reaching sterilizing room.

Admission Routine. — T.P.R.—individual thermometers are used—kept in containers with 1:3000 biniodide solution. In separate rooms, the temperature, pulse and respiration are kept in mind by the nurse, the hands scrubbed and the data recorded on pad left outside of room;

the nurse's watch is worn on the arm above the elbow. In wards of more than one patient, the T.P.R.'s are recorded on pad in ward; after all are taken, the nurse scrubs her hands and re-copies data in clean book with clean pencil.

TAKING NOSE AND THROAT CULTURES.—This requires two nurses, sometimes three, if the child is restless and restraint is necessary, the one holding the child and the one taking cultures becoming contaminated, the third nurse holding clean tubes that thus remain clean on the outside to be sent to laboratory. In the case of a quiet adult patient, one nurse can take swabs and keep tubes clean.

After patient is bathed, examined and all admission routine carried out, the nurse discards her gown, scrubs her hands and arms to elbows for two minutes under running water. There are three gowns kept hanging in each room, one for the nurse, one for the doctor, one for the cleaner. They are replaced with fresh gowns each morning and changed during the day if any unusual contamination takes place, such as patient coughing or sneezing on them, and in replacing gowns on hooks after use they are folded with the inside together, thus keeping free from contamination the surface that comes in contact with clothing.

SERVING MEALS.—Kitchens are always clean. Trays are served from there to the various rooms: they could be delivered to the individual patient free of contamination to the nurse were it not for the salt, pepper and sugar shakers, which are kept in cupboard in patient's room; the nurse takes these from the cupboard, places them on tray, and, of course, this necessitates washing of hands. If the patient has to be fed, the nurse will put on a gown. After meals the contaminated trays are placed on the carriage and taken to a sterilizing room adjacent to the kitchen. Here a maid takes charge; wearing a gown she scrapes all dishes through an opening in a metal table into a garbage can beneath, after which all dishes, including trays, are placed in steam sterilizer for twenty minutes. Then they are removed to clean kitchen and washed. The carriage, table and sterilizing room are scrubbed and made ready for the next meal. Nourishment dishes used between meals are left on a metal table in sterilizing room and sterilized with next meal's dishes.

BED LINEN.—It is not sterilized, but soaked in a weak chloride of lime solution in the laundry and washed separately from other linen. In connection with linen, I would like to mention what I consider one of the greatest safeguards we employ: that is the use of paper napkins instead of old linen or gauze for patients' handkerchiefs. We cut the napkins in four, making pieces about six inches square. These are kept on the bedside table, used only once and placed by the patient in a paper bag pinned to side of the bed, the paper bag being changed frequently. Thus the bedding is kept free from the contamination that must occur when old linen or gauze is used and kept under the patient's pillow or in a pocket of a gown.

NURSES.—Nurses on duty are not segregated from other nurses. They are required to wear different uniform and shoes, and the hair is always confined in a net. When leaving the building they scrub face, hands, and arms to the elbows before resuming clean uniforms and shoes.

VISITORS.—Visitors may come into the corridors and see patients through the glass which separates room from corridor; only in critical cases are relatives allowed in wards and then under close supervision.

TERMINAL DISINFECTION.—The patient is given a bath and shampoo of soap and water in a tub, and the room used only for discharging patients, is dressed in clean clothing, and is then ready for discharge.

Rooms, mattresses, pillows and blankets are sterilized after each discharge, as are also basins and utensils. Bed, table, chair, cupboard, walls,

floors, are washed, and, if possible, left to air for several hours.

CONCLUSION.—The one great drawback to medical asepsis is its time-consuming properties and the increased staff, as it requires almost double. I would say, whenever a necessity for "speeding up" occurs, our technique is almost sure to suffer. Hands are not washed as thoroughly as they should be, gowns are sometimes dispensed with (for it takes time to put on and take off a gown), and disease germs being no respecters of ward conditions, staff shortage, etc., are ever ready to take advantage of any lapse; hence the old proverb once more proves true, "Eternal vigilance is the price of success."

(A paper read at the annual meeting, 1929, of the British Columbia Hospitals Association.)

County Health Units in the United States of America

By LAURA M. GAMBLE, Director, Public Health Nursing Service, Cattaraugus County, N.Y.

The first county in the United States to establish a health department with a full-time health officer in charge was Yakima County, Washington, and the date was 1911. Fifteen years later, on January 1, 1926, the United States Public Health Service was able to count 307 counties or districts which had such a health service.

From 1 to 307 sounds like rapid progress until we remember that there are 2600 or 2700 counties in which the population is wholly or predominately rural. Moreover, at the rate of establishment of county health units which prevailed from 1911 to 1926, it will take over a century for the rest of the rural counties to adopt such measures for the protection of their health.

Meanwhile vital statistics are accumulating which seem to indicate that the rural districts need protection. They show us that since 1920 the rural districts have had a higher death rate than the cities—from 8% to 10% higher.

There may be many explanations for this shift in death rates. Whatever the explanations are, they suggest the need for more thought and action for the protection of the health of the rural population. There is not much difference of opinion, among those best qualified to speak, that the proper foundation for rural health service in the United States is the County Health Unit under the direction of a qualified, full-time health officer. However, county authorities, ordinarily, have not been disposed to appropriate funds for health units unless they could be convinced that public sentiment in the county approved. Therefore, the usual first step taken to secure the establishment of health units was to start a campaign of education to show the advantages and the economy possible in public expenditure.

(Read at the annual meeting of the Registered Nurses of Ontario, 1929.)

CO-OPERATION NECESSARY

In most communities there has been found a large latent sentiment favoring public health work. This sentiment had to be aroused and vocalised. The co-operation and support of the physicians in the county had to be solicited. Frequently volunteer health organisations would help to support and foster the plan: local clubs and associations helped. In other instances, a health committee composed of leading citizens would be formed to stimulate public sentiment. Sometimes an epidemic served to emphasise the need for more adequate health service; again a sanitary and health survey of a county showed the need for corrective measures and brought to light existing inefficiency of a part-time health service.

Except in a few instances, permanent progress has not been made in county health work without financial and technical assistance from outside

sources. The United States Public Health Service, the International Health Board and the different Foundations interested in health work have made funds and personnel available in many states to initiate the development and to assist in the maintenance of county health units.

Legislation

In 1921, the legislature of New York State, acting upon the recommendation of the State Commissioner of Health, registered the opinion through permissive legislation to county boards of supervisors, that the next step in providing effective protection of health in the rural parts of the State was to establish local operating units larger than the townships or villages—in other words, the county unit. Two years later, a law was passed promising financial aid to any county (not containing a city of 50,000 or more) which would take advantage of the permissive legislation of 1921, to the extent of 50% of the expenses incurred.

Two Units Formed

Thus far, only two of the 62 counties of the State have set up county health units. The first was Cattaraugus County, which inaugurated its county health service in 1923. However, other counties in the State have become interested and many health officers and representatives of boards of supervisors and others come to Cattaraugus County to see the work in progress there.

The cost and personnel of county health units vary with the area, population and taxable resources of the county, also with the willingness of the people to provide themselves with a health service.

Appropriations for budgets vary all the way from 25c per capita to $2 and more per capita per annum.

Programmes and activities depend upon budgets and personnel and prevailing local health situations. Each county of necessity "cuts its pattern according to its cloth". Experience has taught us that the generalised nursing service is the most practical one for county units.

Public Health Nurse

The public health nurse has made herself an indispensable factor in this development. From the beginning, she has been a useful and acceptable agent in starting a county health programme. She has been and still is being put into virgin fields by Red Cross Chapters, local tuberculosis associations and others, to demonstrate the initial steps, to sell the idea to county officials and to point the way to the full-time county unit.

Her activities in the rural field of public health, either as a full-time health worker on the county pay-roll or as a member of a county unit, have raised many compelling questions. It may truthfully be said that the present status of rural public health nursing is that of the pioneer stage.

A well-known public health nurse recently said, "There is no single large field in public health nursing, with the possible exception of industrial nursing, which is today more in need of development and study than that of rural nursing"; and those of us who are doing rural nursing will, I think, agree with her in this statement.

What is a well-balanced rural nursing programme? How far can urban routines, etc., be applied to rural communities? What is the rural nurse to do about the social problems she meets in her rural villages and homes? In the face of travel conditions, poor roads, etc., how can the best service be rendered at a reasonable cost? How can rural nurses be provided with proper nursing supervision? These and other questions keep coming up in rural health services.

In Cattaraugus County, where I am familiar with the work and its problems, we have been trying to answer some of these questions.

It has been possible to study and evaluate services there because of the generous grants from the Milbank Memorial Fund, which have made the employment of additional personnel and special workers possible.

Studies are being made there of rural public health nursing relation-

ships, procedures and scope of activities which should be helpful.

If we interpret public health nursing as essentially a family service, including every group, from pre-natal on through to old age, every factor in the environment which has a bearing upon health, must be reckoned within the scope of interest of the public health nurse. In our urban centres, these health needs are met in varying degrees of adequacy. No one is ready to say that rural families should have any less complete public health nursing service; but at the same time, all who understand rural conditions recognise the necessity for many adjustments of nursing services to rural problems.

In closing, I should like to stress what I feel is perhaps the most fundamentally important factor in the success of this field of public health nursing, and that is the preparation of the nurse herself. We give the nurse doing rural work great responsibility—and if she is not prepared to meet it her story is a sad one—she must rely upon her own resources. She often is working alone far from her supervisors. When she has been well-trained and prepared for her work, she is better able to meet the many demands of her district.

We can scarcely emphasise too strongly the need for well-trained public health nurses to undertake rural nursing, and it is a branch of nursing full of interest and satisfaction. It has an appeal typically its own which few nurses can resist when they have once experienced it.

There are still many gaps in our hospital system. Despite excellent public and private efforts, the accommodation is still far from adequate for the incurable, the convalescent, the tuberculous, or the juvenile mentally defective patient. Moreover, the alarming increase in drug addiction and the difficulty of effecting a cure under ordinary home or hospital conditions have focussed attention upon the need of special public facilities for the treatment of these unfortunates, either by the construction of special institution or by a revision of the legal authority and the physical equipment of existing neurological institutions.—From the Foreword of A Directory of the Hospitals of Canada.

NOTES FROM SUBSCRIBERS

"I find *The Canadian Nurse* a most useful journal; the point of view of so many of the articles is more nearly our own than in any of the other journals."—From a New Zealand nurse.

"I am sorry to be late with my renewal for the coming year, but hope it will arrive in time for the next number as I enjoy the magazine very much and do not wish to miss a single copy. I enjoyed the Congress in Montreal so much and am now having the pleasure of reading about it. I am sorry that every nurse does not take our magazine, and hope that this will be the best year in its history."—M. N., Ontario.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

Educational Development in the School of Nursing

By SISTER JOVITA, Director of Nurses, St. Martha's Hospital, Antigonish, N.S.

The educational development which marked the growth of the scientific spirit of the nineteenth century has been carried with tremendous force into this twentieth century. Perhaps there is no branch of science that has developed more rapidly than that which covers medicine and surgery, whilst hand-in-hand with these, though a little in the rear, comes their weaker twin sister, the Nursing Profession. This argues well for the human spirit of the times and brings out into bold relief a noble trait in mankind, an inborn desire to be of service to one's fellow-men. The modern poet has expressed it pithily thus:

"This world of unbelieving hearts
In wonder may behold
Proud Science bend, the slave of Him
Who cured the sick of old."

In face of the astounding development of medical science in this modern age, we may hurl back forcefully the barbed shaft of the older poet who claimed that "Man's inhumanity to man makes countless thousands mourn." Surely, in the light of present-day experience, we can loudly assert that *man's humanity to man* in the Medical Profession has brought relief from misery and pain to *countless thousands* and saved them from an early grave.

Happily, the flame of the scientific torch has also lit the taper of service for the Nursing Profession, for here, too, we find young women prepared and willing to devote their lives for the welfare of their fellow-men, and particularly for the relief of the suffering and disabled.

In the Maritime Provinces we are as yet pioneers in the field, and though our achievements in the past have been somewhat gratifying when we consider our many handicaps, nevertheless we have a long way to travel before we reach the goal of our desires. However, the ascent is an interesting one, and the difficulties and obstacles that beset our daily course can only add to our zest in the climbing process.

The time has come when the people of our fair provinces by the sea happily realise the need of our hospitals in as far as nursing and healing the sick goes. They no longer look upon these institutions with the old-time terror in their hearts, but rather with hope and confidence, as well as appreciation and gratitude. Notwithstanding this fact, the masses of our people do not yet begin to realise the great work we have carried along educational lines through the medium of our schools of nursing. This is a free service which we have willingly given our country. The many young women who are today nursing in the Maritimes are the finished product of our schools, and for the most part they reflect credit on their respective Alma Maters. Our schools, handicapped as they are in many respects, helped not only to keep these young girls at home in a country which is losing thousands yearly through emigration, but

also made them useful citizens. To them the public looks for service characterised by judgment, responsibility, resourcefulness and capability in meeting the problems of health in conjunction with the medical profession. The education of the nurse is a very important contribution as a national service in recruiting the great army of health. When we consider the support and monetary aid which other forms of education receive, whilst we are left to struggle hopelessly with our conflicting problems, we sometimes feel like sinking under the burden. However, with the hand of a kind and merciful God to uplift us, and strengthened by the remembrance of how He has helped us to carry on His great work in the past, we shall resolutely go forward with courage and confidence.

What has been accomplished in the development of our schools of nursing? Regardless of our efforts, we must admit what we have accomplished pales into insignificance in sight of what we hope to accomplish in the future. In the first place, we have raised the standard of our schools considerably, our schools are becoming more educational centres and less workshops than they have been in the past, and, on the whole, we have a better and more systematised organisation than we had ten years ago. However, perhaps our greatest achievement lies in the fact that we realise our needs and that we are anxious to meet them at the cost of much labour and sacrifice.

What, then, are our greatest needs today in the educational development of our schools? *First,* there looms up in large letters our need of better and more highly qualified instructors, and it should be our aim to have at least one Sister on the staff with her bachelor's degree in the science of nursing. *Second,* we should not be too conservative in our ideas, and we must strive to avoid the "psychiological rut" which is so detrimental to true progress. Religious nurses are more apt to fall into this snare than seculars, simply because it is the trend of our lives to follow closely the well trodden path of those who have gone before us. The ancient philosopher, Descartes, wisely advocated a periodical airing of our ideas to eliminate dust and moth, to expose them to the strong rays of the sunlight, discard the useless pieces and repack the valuables for future use. *Third,* we should raise the standard of our schools still higher. No applicant should be considered eligible until she has completed two years in high school at the very least. In fact, a college degree or matriculation would be more desirable. *Fourth,* we should strive to interest the public in the development of our schools and keep educators in touch with what we are doing and with our needs. We should not wait for the public to seek out our needs or read them by signs from the heavens; it is our part of the programme to make them known. *Fifth,* we should look honestly into the defects in our systems. No system and no school is perfect, and we should constantly and vigorously attack defects, eradicate them and supplement only with the very best we can find in systems that have been tried and proven. *Sixth,* we are still somewhat inclined to stress too much the practical side of the nurse's education and the intellectual side too little. The student should have a broad knowledge of her subject before she applies it to the patient. The technical knowledge should be instilled first, and the practical work ought to be introduced gradually in order to train our young women for effective service. *Seventh,* though our schools do not provide for specialisation in any line of nursing, educators claim that one of the functions of the three years' course is the testing of special interests and aptitudes which the student may show during this period. We should at least be able to give her in the third year a practical insight into the main types of nursing service. If instructors are on the alert, there will be many opportuni-

ties ordinarily offered the pupil which will help to determine where her chief qualities lie, whether in the line of executive work, public health, pediatrics, teaching, supervising or other types of nursing service. In fact, the third year work should be as truly elective as we can possibly make it.

To sum up, then, in order to secure the fullest educational development in our schools of nursing we must be prepared to conduct schools which will meet *all* the requirements, intellectually, morally and physically, whose standards are high, and whose faculty and staff can inspire the student nurse with lofty ideals and high principles, and enable her to realise more clearly and definitely the responsibilities of her chosen profession.

(A paper read at the annual meeting, 1929, Maritimes Hospitals Association.)

Eliminating the Unfit from the School of Nursing

By ELIZABETH W. ODELL, Director, Evanston Hospital School of Nursing, Evanston, Ill.

A question which grows out of the preliminary report of the committee on the grading of nursing schools and its graphic presentation of the rapidly increasing surplus of graduate nurses is : "What is our responsibility with regard to eliminating the undesirable and mediocre from our schools?"

The question might be discussed under three headings: (1) elimination of candidates before they enter, this to be done on the basis of their application; (2) elimination on admission; (3) elimination during the course.

First, let us consider the letter of application itself which we may presume is intended to convey the best possible impression. If the letter is untidy, slipshod and misspelled, the director does not feel disposed to encourage the student without at least insisting upon a personal interview. Would a mental test given at the time of the interview help in checking on the information given?

As the students get well along into the first or enter the second year, the problem becomes more complex. There are the doubtful ones, who may develop later. Sometimes they do. I believe they should have a definite understanding of their status in the school. There are some students who have made a good beginning, especially while under the close supervision of the preliminary period but who slump later, perhaps because of an emotional instability not recognised at first or because of the overwhelming experience of living in a big city. There are the few who make serious and unnecessary mistakes and from whom we must protect future patients. Last but not least, there is the occasional student who possesses that intangible something which creates a bad influence in the school but on which it is so hard to lay a finger.

Rarely should it be necessary to dismiss a third-year student.

Physical Condition Important

Next comes the question of physical condition. Unfortunately all supposedly complete records of physical examination leave something to be desired, but when we meet with findings such as "systolic murmur," "enlarged thyroid" or "fallen arches," are we justified in subjecting the candidate to the expense necessary to enter a course from which she will probably be obliged to

drop out or to struggle through for three years only to find herself unfit for the strenuous work of a graduate nurse?

In this connection may also be considered educational qualifications. In demanding a high-school education as a prerequisite, it may be assumed that the school of nursing intends to give a course in advance of high school work, or of university grade. Should we accept as candidates those students who rank in the fourth quarter of their class and whose grades are so low that no high school principal will recommend them for college work?

Let us also consider the entrance age. Could we possibly raise the requirement for entrance to twenty or, at least, to nineteen years?

Seldom does a large class enter a school of nursing that it does not become necessary to eliminate some students during the first few weeks. After a careful physical examination by a member of the staff, there are always found physical defects, not previously reported, which make it impossible for the student to continue her work. I have in mind a case of high blood pressure, high metabolic rate, and a definite thyroid enlargement. Then, there is the occasional student who is undesirable personally and who will not fit in with the class of young women that the school wishes to hold as its representative. Finally, there is the student who fails to grasp even the most elementary part of the work and who makes her teachers wonder how she ever completed her high-school course.

Selection Is Sometimes Difficult

So far we have attempted to separate the wheat from the chaff, but the problem is not so simple as it sounds. The director of one school, when she found that she had more than the necessary number of applicants for September, after careful scrutiny of the application forms and as many personal interviews as possible, postponed what seemed to be the least desirable material until February. The February class turned out to be the better group of the two.

The whole problem is a difficult one and admits of no immediate and sweeping method of solution. For a number of years the vital question has been to secure enough nurses to take care of the patients in the hospital, and to meet the public need later. We have not always recognised the importance of employing qualified instructors who are capable of judging the calibre of the student, nor have we stopped to consider the economic loss of carrying a weak student through only a part of the course. There has always been, and will be for some time to come in many hospitals, the financial question or, in other words, the need of getting enough persons to do the work regardless of their eligibility for a profession.

There are, however, two suggestions which might be offered as a beginning toward solving the problem.

First, when a school of nursing, probably in the face of financial necessity and in urgent need of an extra pair of hands to carry on the work, has had the courage to dismiss a student because she is considered unworthy of the nursing profession, let us not receive her with open arms into another school, thereby undoing the good that may have been accomplished at a sacrifice. It never pays.

Second, if even 1,500, out of the 2,000 or more schools of nursing, would take the advice of a prominent administrator and eliminate each year two mediocre students whom they might otherwise keep merely as a means of getting the work done, employing in their places two well qualified general duty nurses, by such action they would reduce the annual output of poorly qualified graduates by about 3,000, and at the same time take care of an equal number of unemployed.

(The Modern Hospital, October, 1929.)

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
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Correspondence re Constipation—Its Cause and Correction

Following the publication of "Constipation, Its Cause and Correction," in the October number of "The Canadian Nurse," a letter was received from a private duty nurse. A copy of this letter (published herewith) was forwarded to Dr. Page, who has kindly sent a reply in which the several points raised by our nurse correspondent are explained. Dr. Page's reply is also published herewith.

To the Editor,
The Canadian Nurse.

In reference to an article published on the Private Duty Nursing page of the October number of "The Canadian Nurse," entitled "Constipation, Its Cause and Correction,"I should like to refer to a statement of Dr. Page's, and if I may be permitted, repeat a question, which Dr. Page says "troubles the minds of some patients" (and some nurses, too, Dr. Page), that is, "Is there any danger in the use of mineral oil as a causative factor in the production of cancer?" Dr. Page says, "this idea must have been obtained from some published article, but we are unsuccessful in finding anything dealing with this subject." Now I should like to refer Dr. Page to a book published, I believe last year, and entitled "Cancer: The Surgeon and the Researcher," by J. Ellis Barker, with an introduction by Sir W. Arbuthnot Lane, Bart. (pub. by John Murray), in which, quoting from page 275, is the following assertion: "We have seen so far that cancer may be caused in otherwise healthy men by chronic poisoning with x-rays, radium rays, arsenic, aniline, tar, pitch, paraffin, etc." He also gives some data on the prevalency of cancer among tar and paraffin workers, and finds this a fact of great significance in its bearing on the central problem, which is the steady increase of the disease in civilised countries.

A review of this book was published in a Winnipeg paper (I believe the Tribune) on September 4th, 1928.

Now, perhaps Dr. Page or someone else could explain to us why working in paraffin might produce cancer, while taking it internally might be harmless or beneficial.

One more question which is also puzzling and bears on the same subject. A cancer cure has just been claimed in the case of a resident of Frankton, New Zealand, by means of injections of kerosene given at a high temperature. The patient was pronounced incurable by authorities of an Auckland hospital two years ago. After repeated injections the patient, however, has not shown any signs of recurrence of the disease. An official of the health department who examined him found that only a cavity existed where the previous cancerous growth had been, and expressed the opinion that the cure had been effective.

Now I know there is some difference between paraffin and kerosene, but why one might produce cancer under certain conditions and the other cure it under other conditions is not just clear to an unscientific mind. An article dealing with the subject would

be of great interest, as Dr. Page tells us that, "Mineral oil is our greatest ally in combating constipation, being second only to dietetic measures," it seems a pity that any sufferers from that complaint are held back from making use of its benefits by a sense of fear that it may at some distant day be found to be the contributing cause to their having developed an internal cancer. If this fear can be proved to have no foundation worth considering, the sooner it is dispelled the better.

Dr Page's reply:

In reply to the query arising from my recent article on constipation which appeared in "The Canadian Nurse," October, 1929, as to possibility that mineral oil might give rise to malignancy of the bowel if taken over a prolonged period of time, I might say that such is a question that has been considerably discussed in the past, and while there has been no proof as yet that such may be the case, there is an abundance of evidence to the contrary.

Dr. Ellis Barker in his work on cancer, published by John Murray in 1924, states that while the term paraffin cancer has now seemed to have gained general acceptance in the literature, the probability that such is a misnomer seems highly likely. Although workers constantly exposed to tar, pitch, and paraffin, for a period of ten years or over, may develop a cutaneous malignancy, it would seem that such is due to the impurities contained in these products rather than to the products themselves. This is supported by the fact that while the petroleum of both Canada and Pennsylvania is richer in paraffin than that of other countries, and yet the incidence of the dread malady in these fields is no higher than elsewhere throughout the world. Furthermore, Dr. Kennaway, of the Cancer Hospital Research, in the journal of Industrial Hygiene, volume five, 1927, states that he has observed many women who have worked for years in constant contact with refined paraffin, and has as yet seen or heard of no ill effects from such work. We all have seen countless patients of cancer age who have been taking mineral oil for long periods, and yet have like Dr. Kennaway seen no detrimental results. There are many possible impurities that might prove to be the underlying cause, and many of such have been investigated. The olefines, naphthines, anilines, arsenic, phenol, pyerrol, etc., but as yet no one has been able to prove which of these it is, if indeed it is any; but all seem to agree on one point, and that is that the causative agent, whatever it may be, is removed by the refining process demanded by government regulations before it be sold for internal medication. The process consists essentially of four stages—the removal of the carbonised matter by sulphuric acid, followed by treatment by caustic soda, then neutralisation, and with filtering through finely ground charcoal.

The second question asked is a probable explanation for a supposed cancer cure claimed in the case of a resident of Frankton, New Zealand, by the injection of superheated kerosene. I feel that those interested solely in the investigation of cancer could much more ably deal with this question than I. I could find no record of the cure cited in the New Zealand or Australian journals of the past three years, and with all the world groping for any possible cure, it seems that if such a cure had been established in any country it would have been given immediate world-wide publicity. There are few chemicals that have not been tried; as yet all have proved universally unsuccessful. Drs. Marsh and Simpson in the journal of Cancer Research, volume 11, 1927, give a series of cases where the administration of tar derivatives, both subcutaneously and intravenously, have been tried experimentally on animals with cancer, and have all given negative results.

The diagnosis of cancer is not al-

ways an easy matter, and one would have to know whether or not the diagnosis in this case had been established by microscopic section. Many supposed malignant growths and lesions have responded to the administration of potassium iodid, which were later proven to be luetic in origin. Again, the kerosene is stated to be superheated, and is it not possible that such explains the disappearance of the growth by cauterization rather than by any chemical action? The removal of the primary growth in the advanced stage is often useless, due to the presence of multiple secondaries in the liver or elsewhere. Could it have been on these grounds that the case was deemed hopeless? Perhaps the later developments may explain the reasons for its failure to gain more widespread recognition.

Adult Nervous Troubles

When lecturing at the British College of Nurses on the "Past and Present Views concerning Nervous Diseases," Miss Mary Chadwick, S.R.N., F.B.C.N., in discussing the nurses' part in adult nervous troubles, said:

"It is useless to disguise the fact that the nurse has a difficult rôle to take in nursing adult neuroses, so that she may be able to help her patients without becoming involved herself in their symptoms. So that this may be accomplished successfully, she needs to know her own psychological tendencies well and be able to recognise nervous symptoms wherever she sees them, either in herself or her patients, because it is by no means rare for the unconscious mind of the nurse to respond by some echo of forgotten events of her childhood to the requirements and nervous symptoms of her patients. This will usually be the reason why nurses find the nursing of these cases so tiring and exacting for their patience, since old conflicts are recalled in some way by their patients. These are complications that need considerable study, because they are of grave significance and require thought by all those who undertake this branch of their profession.

"We may ask ourselves, *what do patients want of the nurse who attends to them when nervously ill?* First and foremost, they wish to find a kind and loving mother endlessly understanding, patient and sympathetic, a tower of strength to balance the weakness they feel in themselves, and upon whom they may lean. Upon occasions, we may also find patients who want the stern, almost tyrannical mother, who is dictatorial, even rough, whose orders they feel forced to obey and whose treatment helps them to feel they are suffering a pleasant martyrdom. The idea of illness is often confused with that of self-punishment, through the medium of guilt, so that the patient will believe that some ancient or forgotten sin of childhood is being amply atoned for. This will sometimes even hinder recovery, because it will seem wrong to interfere with the course of expiation or even, perhaps, with the Hand of God, Who punishes with this affliction.

"It is essential for the nurse to remember that there are serious reasons why she should hesitate *to practise psychotherapy herself upon the patients she nurses*, as it is better carried out by one who has no personal relations with patients such as she has, and it needs long and intensive study, that even suggestion is hedged about with dangers and difficulties, but that three powerful weapons hang in her armoury nevertheless: the *Transference*, *Identification*, and her own *Unconscious Mind*, perhaps the most important of all if she understands it."

(The British Journal of Nursing, April, 1929.)

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

Mental Hygiene and Public Health

By Dr. S. R. LAYCOCK, Department of Education, University of Saskatchewan, Saskatoon.

I consider it a very great honour to be allowed the privilege of addressing a group of women whose professional activities place them in the vanguard of those who earnestly strive after that great end — the happiness and welfare of mankind. Perhaps at first thought, it may seem strange that an educationist should be asked to address you, but deeper reflection will reveal the fact that our respective spheres of activity are greatly interlinked, and that, after all, we do battle in a common cause. From our side we have come to realise more and more that education is adjustment to life and that if we analyse the major interests and activities of that life to which we seek to adjust the child, health will be found as the most fundamental of all those activities and interests. So more and more schools are realising that one of their major responsibilities is health education: a health education which means more than information but which involves the building of health habits, and attitudes, and the formation of a health conscience. Turning to your side of the question, the medical and nursing professions are finding increasingly that human welfare and happiness depends not only upon having well bodies but also well minds and that psychological processes enter largely into the treatment and care of the sick.

As Dr. Blatz says in a recent book, "We do not know ourselves and the workings of our minds simply through the fact that we have a mind any more than we understand the workings of our body and how best to regulate and control it merely because we have a body. Certain obvious things about the operation and hygiene of the body we all know and heed but when faced with the malfunctioning of the body we readily acknowledge our ignorance and appeal for assistance to the medical man and the nurse. But how different is our attitude concerning the operations of our minds. Our mental processes — our sensations and perceptions, our memories and our ideas are our most vivid and persistent possession. Nay, indeed they are our very selves, and yet we rarely pause to analyse or to understand or to study their intricacies. And when we are faced with any difficulties concerning them our inclination is not to appeal at once for skilled assistance but to conceal those difficulties lest we be considered queer, abnormal or inferior." This attitude is perhaps not to be wondered at. It is, first of all, intensified by social pressure and convention but it is more than that. It indicates that mental processes are so bound up with the realities of life that the frank examination of them presents a difficulty. Secondly, it indicates that notwithstanding the fact that these mental processes are forever with us, they are no less intricate, puzzling and subject to major and minor disorders than our bodily processes of which we are less directly aware. Finally it suggests that the old maxim of Socrates, "Know thyself," is today taking on new meaning and leading us slowly but surely to a broader conception based upon a fuller knowledge. And

(*Read at the annual meeting, Saskatchewan Registered Nurses Association, April, 1929.)

so today there is gradually growing up a body of principles in mental hygiene which in years to come will play as fundamental a part in public health as the principles of physical hygiene are doing today.

The idea of mental hygiene is not new. The principle was clearly indicated by that great old intellectual giant—Plato—when he urged upon physicians to consider the souls of their patients as well as their bodies. But in the period between then and now the attitude of humanity towards the problem of mental malfunctioning presents a sorry spectacle. In primitive times individuals afflicted with mental disease were often regarded as inspired by the gods or as possessed by evil spirits. In the former instance they were frequently revered as oracles and prophets, in the latter they were shunned or turned over to the incantations of the medicine man. At a later period after the Christian religion had obtained a firm foothold and the old gods were relegated to the status of demons, abnormal behaviour due to mental troubles was regarded as indicative of communion with evil spirits and much of the witchcraft persecution was levelled at individuals whom modern psychiatry would class as victims of mental disorders of one type or another. In some instances, it is true, in which the disordered mind became warped along religious lines, the victim was looked upon as a saint, and treated with reverence and respect. But these cases were few in number and could not begin to balance those whose mental illness resulted in untold suffering at the hands of their superstitious companions.

Even when superstitious fears did not actually lead to the persecution of the insane as witches, they were still regarded as a menace. During the 17th and 18th centuries they were thrown into dungeons, along with paupers and criminals, where they languished in chains, with which they were bound so that they might not inflict injury on themselves or others. Even the asylums of the 19th century, although they made some effort to provide medical care for the mentally ill, still clung to the tradition of chaining. As the physicians in charge of these asylums learned more and more about their patients the treatment of the insane gradually grew more and more humane. Other methods replaced chains but it was a long time before the patient suffering from mental disease was left comparatively free as in the psychiatric hospitals of the present day. The necessity for the use of straight jackets and isolated cells is decreasing in those mental hospitals which are most progressive along the lines of modern psychiatry.

With the institution of less rigid treatment, however, a few of the insane recovered. This attracted the attention of the medical profession, and they began to apply the same careful attention to the study of mental diseases as they had previously to physical maladies. And just as in the field of physical disease, attention was first centered upon the more blatant disorders and upon therapeutic measures for those who were already diseased and only later was attention directed to the great field of prevention of which our present great interest in public health is a part, so attention in the field of mental diseases was first focussed on the study and care of those cases whose mental illness was sufficiently severe to place them in mental hospitals, and who were often chronic cases and only later did the idea of prevention arise. And just as through proper sanitation, through ensuring pure water and pure milk supply, through vaccination and inoculation, and through the general principles of hygiene applied to everyday life public health has made tremendous strides so the present movement in mental hygiene still in its infancy, is engaged in efforts to discover methods that will likewise do much to prevent mental disorders.

In Canada the Canadian Committee for Mental Hygiene celebrates this year the eleventh anniversary of its birth. Its purpose is two-fold. First, the prevention of nervous and mental disorders, and second, the better care and treatment of those afflicted. It attempts to achieve its results in three ways: by education, by dissemination of knowledge concerning the facts, and lastly, by research.

Some of the facts are astounding in their revelation. Last year there were 24,000 patients in our public mental hospitals and their upkeep was maintained at an annual cost of $9,000,000. Dean Martin, of the Faculty of Medicine at McGill, is responsible for the statement that there are more hospital beds occupied by mental patients than there are patients in all the general hospitals of the land. If to this is added the fact that there are as many insane mental patients outside of mental hospitals as there are in them, the magnitude of the problem is appalling. Further, Canada has at present 60,000 of pronounced mental deficiency, not to mention tens of thousands suffering from more or less serious nervous disorders which can neither be classified as insane or mentally deficient.

Furthermore, Dean Martin in his presidential speech (The Canadian Nurse, February, 1929) of last year made the statement that approximately four per cent. of all school children (a greater number than graduate from our Canadian universities) are in need of mental hygiene treatment, without which they will inevitably become the victims of grave forms of mental disorder.

What, then, is to become of our national efficiency when mental defects result in greater national degradation than all the physical disorders combined?

These are some of the facts brought to light by our National Committee, and they have followed up these facts by a campaign of education which is gradually introducing a new point of view into the attitude of the general public towards this problem.

Our first need is a changed psychological attitude towards the whole problem of mental disorder. Many of us have still clinging to us the dread of the asylum of olden days, which we thought of as a place to be shunned and feared and we are still apt to regard the sending of any of our friends there as the greatest of all disgraces. This attitude must pass. The insane are not different kinds of creatures. They differ not qualitatively but merely quantitatively. Mental disorders enter into the experience of every human being: it is only a matter of degree whether our disorder be some emotional disturbance, some kink in personality or a grave psychosis demanding custodial care. This is the modern view supported by scientists the world over. Why, then, should we not learn to face frankly that the morbid jealousies, the seclusiveness, the emotional upsets and the nervous dyspepsia are just as much mental disorders as is dementia praecox: for do they not arise from the same group of factors, some of them mild in type and others more severe?

Dean Martin says: "There is a good deal of misconception as to the significance of the term insanity. Insanity is really a legal term to be adjudged by the courts, not by the physician. It is merely the end product of mental and social failure, of the same group of disorders that induce the tantrum in the child, the anxiety neurosis in the girl, and the many emotional disturbances that affect life in the home."

Dr. Winslow, professor of public health at Yale, said in a recent address that the first difficulty to be overcome in a mental hygiene programme is the idea that there is a sharp line of demarkation between the sane and the insane. He further goes on to say that while it is necessary from certain legal standpoints

in an individual case to say that a person is sane or insane, yet just as there is no sharp line between those who are sick and those who are well in a physical sense, so there is no sharp line between the sane and the insane.

If, therefore, we are going to progress with an adequate programme of mental hygiene we must realise that mental hospitals are *hospitals*, namely, that they are merely a special kind of hospital where a special kind of illness is treated just as sanatoria are designed for a special kind of illness. Just as people suffer from illnesses connected with the heart, the lungs or the digestive system, so people suffer from illnesses of the brain and nervous system. As our brain and nervous system is the most delicate and complicated part of our being it seems reasonable that there will be diseases connected with it as well as other parts of our anatomy.

Another change in viewpoint that must come is in connection with the stigma and blame now attached to mental troubles. If blame should be attached it should be attached equally to all physical diseases. It should no more be attached to mental troubles than to pneumonia or tuberculosis. We never think of blaming a lame man, with whom we are walking, because of his limp yet when working on a committee with a man with a mental limp we blame him. Indeed, the accidental injury or the communicable disease may be result of wanton carelessness and the person with the lame leg or cold in the head may be really much more censurable than the person who is irritable, suspicious or difficult, or the person who is dull, slow or over conservative. Our ideal in dealing with the problem of mental deviation is to lay aside all thought and all feeling of praise or blame; to study the individual reaction, to describe what we see and then to prescribe for that condition in so far as it has been revealed.

One other point in current popular thinking — mental deficiency and mental disorders or insanity are greatly confused. We must see clearly that these are two separate problems. Mental defectives suffer from an arrest of development from birth or from an early age. They have the mental maturity of ordinary children of 3 years, 4 years, 6 years, 8 years or 10 years, whatever the case may be. In other words they never have had normal adult intelligence. The insane are those whose minds have developed to various degrees of mental maturity, including normal and brilliant, and then have become organically diseased or functionally deranged. With the mental defectives science can as yet do little so far as restoring them to normalcy is concerned. They need education and training to develop them to the limits of their capacities, and with the higher grades to enable them to become self-supporting and self-respecting citizens.

The next point I want to raise is that of the relative importance of heredity and environment. This is a very large problem and while it is probably true that not only a large proportion of mental defect but also mental disease is hereditary, we must remember what that means in the latter case, is that certain individuals are born with a constitutional endowment that imposes certain limitations on what they can do and lays down lines of sensitiveness which it is worth while to respect. Yet our lessons from the war neuroses have shown that in any given community there are certain individuals whose mental equipment or mental balance is adequate and efficient to enable them to fulfill the responsibilities of their ordinary daily life but who, when subjected to a special stress, to an abnormal condition, when taken from their families and transplanted to an alien environment, with military discipline and war conditions, found that this equipment failed to work. Every person has a certain capacity and if he goes beyond that capacity he breaks. There are individuals who

live normal lives in the community so long as the weather is clear, but if the storm comes, if financial trouble arises, if an emotional crisis occurs, they break under the strain. As Dr. MacFie Campbell, of the Boston Psychopathic, says: "The fact that a person has an upset *of a certain type* may be due to the constitutional tendencies of that person, but the fact that the patient has an upset *at all* may be due to a special stress, a bereavement, an acute disappointment, an inner conflict, or a mounting tide of regret or remorse, for which their early adjustment in school and home did not prepare them." And Dr. Campbell goes on to say: "It does not do to look upon the attack as a predestined episode born to occur. Rather the fact that a poorly endowed person developed mental disorder at all may well be due to the fact that important issues in life were given a false value from the beginning, that the individual got little training in subordinating his demands to those of the group, in controlling the facile development of phantasies, in facing openly and intelligently the inevitable conflicts which exist in every individual. In all such cases where careful study is possible one can hardly fail to attribute considerable of the disaster to the influence of the home, the school, the economic and social environment. While one can admit that all men are not born equal with regard to constitutional endowment one must also remember that the later balance of the individual is going to be in large measure determined by the moulding influences to which he is exposed. These are the considerations that are in one's mind when one is studying in the individual case the origin of delinquent behaviour, the hysterical paralysis, the ill-balanced sexual life, the deep-seated depression, the restless discontent, the feeling of futility or the ideas of persecution with which the psychiatrist has to deal.

In dealing with the prevention of mental disorders let me remind you again that it is not merely the disorders of people who happen to be mentally crippled and living for long periods in mental hospitals, one must think too of that host of milder mental disorders of which I shall speak in my second lecture and have produced eccentric, embittered, inhibited and distorted personalities, and make for such a huge proportion of human unhappiness. Here the trail leads more and more back to childhood and so we will consider for a few minutes some of the influences that mould or fashion these personalities and the adjustments the child has to make.

The new arrival on this earth is first of all faced with the simple tests of nutrition, of sleeping and of acquiring habits of cleanliness. During the first year the natural self-assertiveness of the individual meets with conflicting forces and his tendencies tend to become moulded and modified. The development of undesirable emotional traits in this period are in large measure due to the emotional weakness of the mother who may be guided purely by her personal feelings of affection or by laziness. Or else she may err through ignorance of what should be done. The child, therefore, decides its own bedtime, its own diet, and pays no attention to cleanliness and thus enters into the play period of life with a rather poor equipment with regard to manual activities, social relationships and habits. The child finds he must adapt himself more and more to the group. He finds that activities apparently natural provoke strong emotional reactions in the environment, and learns to adapt himself in some sort of way to these values. Some actions excite disapprobation and withdraw affection, some are punished, some topics cause horror and some are so mysterious that they cannot be even mentioned. The result of these years is largely determined by the emotional values that permeate the atmosphere of the child and which, as a rule, are not carefully elaborated products, but

are merely the expression of the emotional attitudes of the parents based upon their own constitutional difficulties and life experiences. In this period the child life is deeply stamped with a set of values, often a false and unreal set, derived from the personality, the reactions and the pronouncements of the parents.

In the school, both in the classroom and on the playground, the child prepares more seriously for the real tasks of life. He has a more impersonal discipline and he has to adapt himself to a wider group. He comes from a home with its special emotional values to mix with children whose values may be quite different. He comes from an atmosphere which may have fostered his sensitiveness to an atmosphere that may even be mildly hostile. He comes from a playground where he may have been king to a playground and school where he may be treated with little consideration. He may find that measured by the rest of the group there is a variation from his own estimate of himself. His marks may be poor and in games he may not be very successful; in social contacts he may not be able to make friends quickly; he may find that he is not personally liked, and that the boys keep aloof from him. The different standards of his comrades produce conflicts. They may look on honesty, truth and purity in somewhat different ways from what he does, their stories and behaviour may excite him; they may even get him to experiment with sex behaviour.

Due to inadequate preparation and the development of faulty values and attitudes in the pre-school years these conflicts that arise in the school child give rise to a host of behaviour problems and personality maladjustments that undoubtedly are fruitful sources of delinquency, psychoneuroses, and other forms of mental disorders. Has not the time come when attempts should be made to stop this stream of disorders more nearly at its source? The Provincial Department of Public Health of Saskatchewan, realising the tremendous cost of institutional care and the tremendous wastage of human material has, with fine vision, entered upon a scheme whereby with the co-operation of the Canadian National Committee for Mental Hygiene and the University of Saskatchewan, a division of mental hygiene in the Department of Public Health has been formed. This, according to a recent announcement of the minister of public health, will consist of the part time services of a government psychiatrist, social worker and psychologist. All three will, it is hoped, within a year's time, cooperate in a demonstration of mental hygiene clinic to be established in Saskatoon which will deal with mild mental disorders in the hope that many cases may be readjusted and thus prevented from becoming patients of our mental hospitals. The psychiatrist and social worker will make a study of the possibility of placing selected patients in selected homes for care and the psychologist will make a study of the personality and behaviour maladjustments of school children in an endeavour to discover early traces of conflict and to head off more nearly at their source the mental disorders that cause so much unhappiness and suffering. Behaviour problems will be studied from the standpoint of diagnosis and treatment. If a patient comes to a doctor with a pain in his head the doctor does not say "naughty bad head," he tries to diagnose the roots of the trouble. If a child steals or is obstinate or sulky or bullying or nervous or shy or domineering, it is not adequate to say, "naughty, bad child." The case must be *diagnosed*, for the psychologist goes on the assumption that all forms of behaviour have a cause, often very complex and often far back in the history of the individual: a cause to be carefully sought out and remedied by adequate treatment.

There are many other aspects of an adequate programme of mental

(Continued on page 735)

Book Reviews

Surgical Nursing, by E. L. Eliason, M.D., Sc.D., L. Kraeer Ferguson, M.D., and Elizabeth Keller Lewis, R.N. Published by J. B. Lippincott Company, London, Philadelphia, and 201 Unity Building, Montreal. Price $3.50.

In this book the authors have very carefully explained surgical nursing and procedures, and have drawn upon their own experience, both in hospital and class room. In many cases, not only have they given the reason and method but have given sections in anatomy and physiology to better explain the procedures. Splendid illustrations are shown throughout the book.

The first few chapters deal with Bacteriology and inflammation, antiseptics and antisepses, and anaesthetics. Methods in surgical nursing, pre-operative and post-operative care are described in a manner interesting and comprehensive.

Fractures and bandaging are not forgotten, and are dealt with in a practical way, showing splints and appliances in common use, and the preparation and appliance of the plaster bandage.

The chapter on Operating Room Technique should be of valuable assistance to any nurse.

Eye, Ear, Nose and Throat conditions have been clearly dealt with, and a brief outline of the essential anatomical and physiological facts are presented, also the drugs commonly used in treatment, and the care in each disease.

As this book covers all branches of surgical nursing in a very descriptive and practical manner, it should be of value to the student nurse in her case studies.—ANNA L. MCNEILL, Instructor, Winnipeg General Hospital.

An Introduction to Efficient Study Habits, by Maud Blanch Muse, R.N., A.M., Teachers' College, Columbia University. Published by McAinsh & Co., Limited, Toronto. 110 pages. Appendix, Bibliography, Index. Price $1.00.

"The excuse for this monograph is that, to the author's knowledge, the subject has not hitherto been presented from exactly this angle. So brief a discussion cannot aspire to be more than an introduction to efficient learning techniques, but hope lies in the attempt made *to stress the psycological laws and principles which underlie each study method advocated*". The stressing has certainly been done: no less than three per cent of the text is taken up by the italicised versions of four laws and five sub-laws of learning, and their alternative names. Presumably as an exercise in learning the student is presented in one case with seven different names for the same law, to one of which even Pavlov's dog is tied. Ironically enough, the author reads herself a lesson in the avoidance of tautology by quoting James' simple formulation of the same law: "Put together the things which belong together."

If the reader can bring into play a principle of learning which is not stressed in the text, viz., that of disregarding non-essentials, she may doubtless profit by the many helpful suggestions which are given.—BROTHER R. PHILIP, Department of Philosophy, University of Alberta.

Directory of the Hospitals of Canada: A Directory of the Hospitals of Canada with Maps, compiled by the Department of Hospital Service, Canadian Medical Association and issued by the Department of Pensions and National Health for Canada. Forty-four pages.

As explained in the Foreword, the purpose of this booklet is to make readily available a list of the hospitals of Canada.

In Part 1, the hospitals are listed according to provinces under the following headings: Public Hospitals; Special Hospitals (including tuberculosis institutions); Pediatric Hospitals; Public Maternity Hospitals; Red Cross, etc.; Government Hospitals (including S.C.R.); and Private Hospitals.

A special classification of Hospitals is made in Part 2 as: Department of Pensions and National Health (S.C.R.); Red Cross; Pediatric; Orthopedic; Public Maternity; Tuberculosis; Mental and Neurological; and Hospitals for Incurables.

The total number of beds in each hospital is given, together with the number in each available for maternity and pediatric cases.

The report explains that while every effort has been made to verify information published, the expansion of hospital facilities has been so great in recent years that available statistics very soon become obsolete.

The Directory shows that there are 215 hospitals which conduct schools for nurses.

BOOKS RECEIVED

Diseases of Children for Nurses, including Pediatric Nursing, Infant Feeding, Therapeutic Measures Employed in Childhood, Treatment for Emergencies, Prophylaxis, and Hygiene: by Robert S. McCombs, M.D., Instructor of Nurses at the Children's Hospital of Philadelphia. Sixth edition, illustrated. Published by W. B. Saunders Company; Canadian Agents, McAinsh & Co., Limited, Toronto. Price $2.75.

PAMPHLETS RECEIVED

The Canadian Council on Child Welfare has issued several recent publications:

An Investment in Health—Hot Lunches for Schools in Rural Districts, prepared by Myrtle Hayward, B.S., School of Household Science, MacDonald College, contains excellent advice and instructions on this subject.

Play and Play Materials for the Pre-School Child, prepared by Harriett Mitchell, B.A., R.N., Director, Montreal Division of Parental Education, is a splendidly illustrated booklet of 64 pages, which covers the subject in the following sections: (a) Play and Play Materials; (b) The Playroom; (c) The Home Playground.

Mrs. Mitchell has also prepared a pamphlet entitled "Group Study for Parents," as well as lists suggesting books for Parents and for Pre-School Children. These are published by the Montreal Division of Parental Education, Canadian National Committee for Mental Hygiene. These publications are welcomed by nurses as every nurse should not only find them interesting, but appreciate their value for parents, school teachers and all others interested in child welfare.

Health Heroes—Florence Nightingale, published by the Metropolitan Life Insurance Company, Canadian Head Office, Ottawa, is a brief, attractively-illustrated biography of Miss Nightingale.

The Care and Treatment of Nervous and Mental Patients in General Hospital, by Emil Frankel, Director of Research, and Thomas B. Kidner, Hospital Consultant, has been published by the State of New Jersey, Department of Institutions and Agencies. Illustrated.

MIDWIVES ORGANISE

Under the leadership of Mrs. Mary Breckenridge, Director of the Frontier Nursing Service in Leslie County, Kentucky, the members of that service formed the Kentucky State Association of Midwives, and recently the Association became incorporated in Kentucky. The purpose for which this organisation was formed is "to foster, encourage, and, in the qualifications for its own membership, to maintain a high standard of midwifery with special reference to rugged, difficult, and economically poor areas; to do this in co-operation with the State Board of Health and the officers thereof, and in co-operation with the medical and nursing professions and with other like-minded citizens and organisations; and thereby raise the standard of midwives and nurse-midwives, who are or have been or may hereafter be engaged in the active practice of midwifery, to a standard not lower than the official standards required by first class European countries in 1929."

As far as is known this Association of Midwives is the first one organised, incorporated, and promoted by midwives in the United States. Mrs Breckenridge is President of the Kentucky State Association of Midwives.

(Continued from page 335)

hygiene on which I have not time to speak. For those patients in mental hospitals who are suffering from functional psychoses high hopes are entertained for the method of occupational therapy of which our institution at Battleford is such a splendid example. The therapeutic process of giving these patients interesting tasks which direct their energies into wholesome and helpful channels is, it seems to me, bound to greatly alter our conception of adequate treatment for the insane. The day when mental hospitals kept their patients sitting on benches around the walls of the ward with attendants to keep them quiet will pass over with a large proportion of cases to that process of re-education which is known as occupational therapy.

The care and education of the defectives is another problem which I must pass over. The low-grade ones can only be handled adequately and justly by separate institutions specially designed for their care and training. The higher-grade ones must be cared for within our present school system by adequate provision for special classes.

In my second lecture I plan to speak on the mild mental disorders of ordinary folk, patients and others. At present I have tried to give you a general point of view. I hope, at least, that what I have said may quicken your interest and enlist your support in an adequate programme of mental hygiene. I know of no body who can render more enlightened and helpful service to the cause than the nursing profession.

(Part II. will be published in January, 1930.)

News Notes

CANADIAN NURSES ASSOCIATION

The Biennial Meeting of the Canadian Nurses Association will be held in the Hotel Saskatchewan, Regina, from June 24 to 28, 1930, inclusive.

The hostess organisation, the Saskatchewan Registered Nurses Association, has appointed the following members to the Committee on Arrangements.

Mrs. W. M. Van Valkenburg, General Convener and convener of the sub-committee on Entertainment. Conveners of the sub-committees are: Hotel Accommodation, Miss E. E. Graham; Registration, Sister O'Grady; Information, Miss J. MacKenzie; Educational Exhibits, Miss C. I. Stewart; Commercial Exhibits, Miss Naisbitt.

The progress report of the Programme Committee (Miss G. M. Fairley, convener), shows that that Committee is preparing an excellent programme; one especially interesting feature being an increase in the number of Round Tables in preference to numerous formal addresses and papers. Each of the three national sections, Private Duty Nursing, Public Health Nursing and Nursing Education, has already referred details for arrangement of Round Tables as well as the general programmes of Sections to the Provincial Sections.

Nomination forms have already been mailed to the federated associations, and before the end of the present month these associations will be notified by the Executive Committee of proposed changes to Constitution and By-laws.

ALBERTA

CALGARY: The Calgary Association of Graduate Nurses held a most enjoyable bridge at the Colonel Belcher Hospital on October 18th. There was a large attendance of nurses and their friends.

BRITISH COLUMBIA

British Columbia nurses sustained an irreparable loss in the death of Mrs. Margaret E. Johnson, R.N., which took place, October 19th, 1929, in Vancouver, B.C. after an illness of several months.

Mrs. Johnson was born in Truro, N.S., and trained at the Boston City Hospital, Boston, Mass. About seventeen years ago she came to Vancouver, taking over the Bute Street Private Hospital, which she owned till 1928, when she sold it owing to ill health. During this time she made it an outstanding success among the private hospitals of Vancouver. She acted as treasurer of the B.C. Hospitals Association for several years, was a member of the Graduate Nurses' Association of B.C., in 1913, and from 1915 till her resignation in 1927 served on the Executive Council of that Association as Secretary, Vice-President and President. She was also President of the Vancouver Graduate Nurses' Association and took an active part in all nursing activities.

To the younger members of the nursing profession her death should be a reminder of the interest and time she gave towards obtaining the Act of Registration and other pioneer efforts of the Provincial Association of Nurses of British Columbia.

GENERAL HOSIPTAL, VANCOUVER: At the November meeting of the Alumnae only a short time was given to routine business, after which the members enjoyed a social evening of bridge. A collection was taken, the proceeds of which will be used in sending Christmas remembrances to graduates of the school who are ill.

Dr. Malcolm MacEachern, Chicago, is once again a familiar figure in the corridors of this institution, and although here as a busy member of the Hospital Survey Committee, he finds time for a friendly word with all old-time members of the staff.

MANITOBA

BRANDON: The October meeting of the Brandon Graduate Nurses Association was held by the Hospital Group at the General Hospital. Miss McNally gave a very full report of the International Congress. A delightful social hour was enjoyed.

The November meeting of the B.G.N.A., met in Dr. McDiarmid's office under the auspices of the Private Duty Section. Mrs. L. H. Fisher, graduate of the Montreal General Hospital, gave a very interesting paper on group nursing and refresher courses. This was followed by refreshments.

NEW BRUNSWICK

MONCTON: Miss Ruby G. Hull, who for the past two years has been operating room supervisor at the Shore Road Hospital, Brooklyn, N.Y., has returned to Moncton, and is at present engaged in private duty nursing. Her many friends welcome Miss Hull back to their midst.

On September 11th, the local chapter of the New Brunswick Graduate Nurses Association entertained Miss Maizie Miller on the occasion of her leaving Moncton to take up a medical course at McGill University. A delightful lunch was served, and a travelling clock presented to Miss Miller from the members of the association, with their best wishes for future success of her career.

Four of the private duty nurses in Moncton have left recently to take institutional positions in the States. Miss Lucy Purdy has accepted a position as night supervisor at the Mount Sinai Hospital, N.Y. The Misses McCarthy and McFadden are engaged for general duty at the Polyclinic Hospital, N.Y., and Miss Dorothy Embree

at the Nassau Hospital, Mineola, N.Y. These nurses will be greatly missed from the local chapter of which they were all active members.

Miss Jessie MacDougall, who spent several weeks visiting at her home here, has returned to resume her duties as obstetrical supervisor at the Homeopathic Hospital, Rhode Island.

ST. STEPHENS: The local chapter of the Registered Nurses Association of New Brunswick met on November 8th, at the home of Miss Mabel McMullen. A delicious basket supper was served. Covers were laid for 19. The table was daintily arranged and decorated with Hallowe'en favours at each plate. After supper the annual reports were read and the usual business was transacted. The following officers were elected for the coming year: president, Miss M. McMullen; vice-president, Miss Jessie Murray; secretary-treasurer, Miss Myrtle Dunbar; entertainment committee, Miss Bertha Gregory, convener; Miss Nellie Lyons, Miss Nellie Spinney.

Miss Ella McBain and Miss Ruth Hagerman have gone to Boston, Mass., to do private work during the winter.

NOVA SCOTIA

HALIFAX INFIRMARY: Sister Catherine Gerard and Sister Rose Angela of the staff, have returned from St. Mary's Hospital, Rochester, Minn. (Mayo's), where they have completed a six months post graduate course in operating room technique.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in November, 1929, were 1,261, twenty-six more than in October, 1929.

APPOINTMENTS

Miss H. D. Muir (Brantford General Hospital), as Operating Room Supervisor in the Hospital.

Miss Frances M. McDonald (Grace Hospital, Toronto, 1919), to the staff of the Radiology Department of the Hospital.

Miss Elsie C. Ogilvie (Grace Hospital, Toronto, 1919), as Assistant Superintendent of Nurses, Neurological Hospital, Medical Centre, New York City.

Miss Beatrice Mae Tunbridge (Grace Hospital, Toronto, 1929), as Assistant Supervisor in the Obstetrical Department of the Hospital.

Misses M. E. Lavis and Mabel Casselman (Ottawa Civic Hospital, 1928), to the staff of the Hospital at Iroquois Falls, Ontario.

Miss M. Simons (Ottawa Civic Hospital, 1929), to the staff of the Indian Reserve Hospital, Brantford, Ont.

The Board of Directors of the Registered Nurses Association of Ontario held a meeting at the Academy of Medicine, Toronto, on Thursday, October 24th, 1929. All but two of the districts were represented, and splendid reports were presented from each district.

The total membership for 1928 was 1387; on October 1st there was a membership of 1,754, showing an increase of 367 members over last year.

There were 694 identification certificates issued to nurses in Ontario who attended the International Council of Nurses' Congress in Montreal in July, 1929.

During the week following the International Congress a number of nurses from foreign countries visited Toronto and surrounding points. The hospitality committee of the Registered Nurses Association of Ontario had headquarters at the Royal York Hotel, Toronto, where a member was on duty all the time. A number of the visitors called, and for many arrangements were made for entertainment, for visits to the various hospitals and institutions, and where necessary, arrangements were made for any who wished to visit other cities in the province.

The next meeting of the Board of Directors will be held in Toronto on February 6th, 1930, when final arrangements will be made for the Annual Meeting, which, it is expected, will be held in Toronto on April 24th, 25th and 26th, 1930.

DISTRICT 1

The Florence Nightingale Nurses Association of Windsor and adjacent municipalities was formed by graduate nurses in March, 1927: membership is limited to those nurses who are not eligible for membership in one of the local nurses' alumnae.

The objects of the organisation are:

(1) To unite the nurses resident in Windsor and adjacent municipalities who are graduates of schools of nursing outside of Border Cities.

(2) To establish and maintain ethical standards among nurses.

(3) To promote the educational and social standing of the nursing profession.

(4) To assist in feasible charitable causes.

(5) To co-operate with District No. 1, of the R.N.A.O., with the Ontario Registered Nurses Association, and the Canadian Nurses Association.

From a small group of seven graduate nurses in March, 1927, this organisation has grown to a membership today of 128, and applications are still being received. All active members are registered nurses of Ontario, but the Association accepts associate members (without Ontario registration), the latter cannot hold office. The organisation is chiefly a social one. There are many married members who enjoy keeping up their professional interest through the Association.

This organisation is affiliated with the Local Social Service Council and renders support to the Victorian Order of Nurses established here in September, 1927. With the opening of the New Metropolitan Hospital in the Border Cities in March, 1928, the nurses undertook the financing of a nurse's room in the Hospital. Christmas contributions are made to the Hospital, Essex County Sanatorium and to the local Victorian Order of Nurses.

The officers are: president, Mrs. R. E. Parker, Jr., Parker Apts., Windsor; secretary, Mrs. Grace Wetmore, Devonshire Apts., Walkerville; treasurer, Mrs. D. Patterson, 1282 Dufferin Street, Windsor.

Executive meetings are held the last Monday of every month.

Regular meetings are held the first Tuesday of every month.

An invitation is extended to any nurse visiting the Border Cities at any time to join this Association. The members try to entertain every professional woman who comes to the Border Cities.

DISTRICT 2

The annual meeting of District No. 2, R.N.A.O., was held at the Kitchener and Waterloo Hospital on October 11th, 1929, Miss E. M. McKee presiding, in the absence of Miss M. Buck, Simcoe.

Miss Wintechalt, president of the local Graduate Nurses Association welcomed the visiting nurses.

The meeting which proved of great interest was attended by over 100 members.

An interesting report was given of the Congress, International Council of Nurses held in Montreal, by Miss MacCormack, Brantford. Miss Elsie Masters, Kitchener, spoke to the nurses on the need of continued interest in publications, both "The Canadian Nurse", and "The International Nursing Review."

Officers were elected as follows: President, Miss N. Buck, Simcoe, re-elected; vice-president, Miss E. Webster, Owen Sound; secretary-treasurer, Miss H. Booth, Simcoe, councillors, Misses Gladys Jefferson, Woodstock, Oxford County; A. Bingeman, Kitchener, Waterloo County; L. Kaempf, Guelph, Wellington County; M. Derby, Stratford, Perth County; I. Davidson, Paris, Brant County; M. Legget, Simcoe, Norfolk County; representatives to sections; public health, Mrs. J. L. Mitchell, Brantford; nursing education, Miss S. M. Jamieson, Galt; private duty, Miss J. Davidson, Paris; finance convener, Miss L. Ferguson, Guelph; membership convener, Miss E. Murphy, Guelph; publication convener, Miss MacCormack, Brantford.

After the election of officers, the meeting formed into the Public Health, Private Duty and Nursing Education Sections. The following members opened discussion: Private Duty, Miss Jean Davidson, Paris; Public Health, Mrs. Mitchell, Brantford; Nursing Education, Miss Jamieson, Galt.

Group nursing, the chief topic presented by the largest attended section, Private Duty, was discussed with great interest, although nothing definite was decided upon, and the subject will consequently receive further discussion at the next meeting to be held in Guelph, February, 1930.

After the adjournment of the meeting, refreshments were served at very attractive tables decorated with Hallowe'en favours. Some of the nurses then visited St. Mary's Hospital, while others, due to the courtesy of the Kitchener Canadian Women's Club, attended an illustrated lecture by Dr. Krupp, of Woodstock, on his trip around the world.

GENERAL HOSPITAL, BRANTFORD: Miss H. D. Muir has been appointed as Operating Room Supervisor following a course in Operating Room Technique at Toronto General Hospital.

Miss M. MacCormack gave a very interesting talk at the Alumnae meeting on the International Congress of Nurses which was held in Montreal, and which she illustrated with several lantern slides.

The staff entertained at high tea for Dr. Chung, of China, who is visiting in Canada.

Miss Jean Davidson has returned to her duties after spending her vacation in Toronto, where she took a course in physiotherapy at the Toronto General Hospital.

Miss Ada Blackwell, Listowell, was recently married in Brantford.

Miss Marjorie Clark, Toronto, was recently married in Toronto.

GENERAL HOSPITAL, WOODSTOCK: A successful tea was held by the Alumnae October 1st, tables in the reception room being made very attractive for the occasion. It was well patronized and brought gratifying results.

The Alumnae entertained the 1929 graduating class, November 1st, to a theatre party, followed by a banquet held at The Masonic Temple Tea Rooms, forty being present for the occasion. An enjoyable evening was spent.

NOTICE

The Brantford General Hospital Archives Committee urgently request a record of all former nurses trained at this school since its inception, 1888-1914. Will nurses kindly assist to further this aim by sending in their names, addresses and year of graduation, also any information re other graduates of those dates to: Miss M. MacCormack, Reg.N., Secretary, Alumnae Association, General Hospital, Brantford, Ont.

DISTRICT 4

GENERAL HOSPITAL, GUELPH: A prominent citizen of Guelph has very kindly donated the sum of $5.00 towards new equipment in the Nurses Class Room.

Miss Grace Kinder, of Strathroy, and a Graduate of Hamilton General Hospital has accepted a position as Instructor at the Hospital.

A very interesting, as well as instructive evening was spent by the graduate and pupil nurses on October 24th. Miss MacDonald introduced the speaker Mrs. Haygarth, of the Social Service Department, Toronto. A number of slides were shown and a short talk given, after which a hearty vote of thanks was moved by Miss Kinder, seconded by Miss Kaempf.

Mrs. Haygarth was the guest of the Alumnae while in Guelph, when she occupied the Nurses Room in the new Y.W.C.A. This room was furnished by the Alumnae.

GENERAL HOSPITAL, HAMILTON: Miss Aileen Strachan (1928), did relief duty

on the Victorian Order of Nurses staff for the month of October.

Miss Violet King (1926) is in St. Catharines with the Victorian Order of Nurses.

Misses Catharine Chapple and Jessie McDonald (1926), have returned to New York after a holiday. Miss Vilma Hutchison returned with them.

Misses Alice Lockie and Georgina Drew (1927), have left to take positions in New York.

Miss Helen Gowling (1929), has taken Miss Lockie's place on the operating room staff.

Miss Marion Harvey is very much improved.

Miss Gladys Ayres (1922), of South Carolina is recovering from a serious illness.

Two bridge parties have been held in aid of the Mutual Benefit Association and were very much enjoyed by those who attended.

On October 26th, a very successful rummage sale was held and $115.75 realised.

A very successful bazaar was held by the Alumnae on Wednesday, November 6th. About $830.00 was realised which is to be given to the Mutual Benefit Association.

DISTRICT 5

The regular meeting of District No. 5, R.N.A.O., was held in Orillia, at the Soldier's Memorial Hospital Residence on Saturday, September 21st. The afternoon session was devoted to business and after supper, served by the nurses of the hospital, a report of the I.C.N. Congress was given by seven nurses who had attended the meetings.

GRACE HOSPITAL, TORONTO: Miss Ida J. H. Lindsay (1916), has recently returned from a trip around the world.

GENERAL HOSPITAL, TORONTO: A most delightful dinner was arranged for and held on Friday, July 12th, 1929, at the Mount Royal Hotel, Montreal, for the graduates of the Toronto General Hospital attending the Congress, International Council of Nurses.

It proved a joyous reunion for all, especially for some of the older graduates who had not met for many years.

Miss Gunn, in her inimitable way, spoke a few cheery words, and brought the dinner to a most successful conclusion.

Those present were: Jean I. Gunn, St. Luke's Hospital graduate, and Superintendent of the Training School for Nurses, Toronto General Hospital; A. J. Hartley (1902), Matron-in-chief of the Pensions and National Health, Toronto; Janet H. Neilson (1897), Supervisor, Yorkville District, Department of Public Health, Toronto; Annie I. Browne, (1895), Private Duty, Toronto; Clara A. Brown (1903), Private Duty, Toronto; Bertha Harmer (1913), McGill University, Montreal; C. Isabel Stewart (1910), Supervisor Red Cross Nursing, Saskatchewan; Mrs. Sarah M. Driver (1913), Industrial Nurse, Harris Abbatoir Company, Toronto; Ethel M. Cryderman (1916), Supervisor, Victorian Order of Nurses, Ottawa; Louise M. Dickson (1916), Superintendent, Shriners' Hospital, Montreal; Mrs. E. M. Feeny (1907), Public Health Nurse, Saskatchewan; Edna M. Squires (1916), Ontario Provincial Public Health Nurse; Mrs. Olive Elwood Smillie (1916), School Nurse, London, Ont.; Alice Thompson (1921), Department of Public Health, Toronto; Margaret Stovel (1919), Department of Public Health, Toronto; Laura L. Rowan (1920), Private Duty, Toronto; Mrs. Helen Cameron Parks (1918), Toronto; Mrs. Margaret Maclennan Smythe (1918), Toronto; Emma E. Augustine (1908), Emergency Work; Helen Longworthy (1922), Red Cross, Saskatchewan; Lorena M. Chute (1921), Staff, Toronto General Hospital; Arlie Harrison (1921), Private Duty, Toronto; H. Caroline Hugill (1921), Private Duty, Toronto; Isabel Kelley (1928), Private Duty, Toronto; Mrs. Muriel A. Martin Hughes (1920), Montreal; Elsie Hickey (1913), Department of Public Health, Toronto; Winifred McCrum (1928), Staff, Toronto General Hospital; Elizabeth Stanfield (1912), Private Duty, Toronto; Merle B. Bruce (1926), Staff, Toronto General Hospital; Annetta L. Landon (1926), Staff, Toronto General Hospital; Margaret Kellough (1926), Private Duty, Toronto; Hazel Quinn (1927), Private Duty, Toronto; Helen S. Locke, St. Luke's graduate, Assistant Superintendent, Toronto General Hospital; Athol L. Beatty (1920), Industrial Nurse, Canadian General Electric, Toronto; Gordon M. Lovell (1920), Department of Public Health, Toronto; Elsie C. Bain (1920), Toronto; E. Elizabeth Mellish (1925), Private Duty, Toronto; Edna L. Moore (1913), Canadian Tuberculosis Association, Ottawa; M. Olive Turner (1917), Private Duty, Toronto; Frances G. Charlton (1925), Staff, Toronto General Hospital; Mary E. Macfarland (1926), Staff, Toronto General Hospital; Agnes C. Neill (1926), Staff, Toronto General Hospital; Nellie Doig (1927), Private Duty, Toronto; Irene B. McElvey (1927), Private Duty, Toronto; Mrs. M. A. Moore (1902), Private Duty, Toronto; Mrs. Ethel Jeffrey Hutchison (1897), Montreal; Elvira Manning (1920), Department of Public Health, Toronto; Marion E. Stewart (1918), Department of Public Health, Toronto; L. Adele Cameron (1926), Staff, Toronto General Hospital; Mrs. Maude Kennedy Hogan (1919), Montreal; Gretta Ross (1919), Department of Public Health, Toronto; Anna M. Oram (1913), Public Health Nurse, Welland, Ont.; Elizabeth Jones (1917), Public Health Nurse, Weston, Ont.; Elizabeth H. Purdy (1905), Staff, Toronto General Hospital; Anne Wright (1919), Superintendent, General Hospital, St. Catharines, Ont.; S. Agnes Campbell (1912); Edna E. Fraser (1911), Department of Public Health, Toronto; Mrs. Bertha Gibbons Bartholomew (1909), Toronto; Madge McCort (1911), Maritime Tuberculosis Educational Association; Mrs. Helen Duff Forgan (1918), Toronto; Margaret E. Orr (1914), Assistant Superintendent, Shriners' Hospital, Montreal; Ethel Campbell (1913), Private Duty, Toronto; V.

Rae Shipman (1921), Red Cross Hospital, Englehart, Ont.; Jean L. Church (1925), Private Duty, Ottawa; Jessie Algie (1921), Private Duty, Toronto; Dorothy M. Percy (1924), Victorian Order of Nurses, Ottawa; Ethel S. Fenwick (1918), University Hospital, Edmonton, Alta; Flora C. Liggett (1909), Superintendent, Montreal Ladies Benevolent Society.

DISTRICT 6

GENERAL HOSPITAL, BELLEVILLE: Miss Dolly M. Church received the scholarship awarded by the Shriners' Hospital, Montreal. The scholarship includes an eight months course at McGill University. Miss Church spent two months as an affiliate student at the Shriners' Hospital about four years ago. Her many friends congratulate her on her award.

On August 15th, 1929, the many friends of Miss Annie Burley gathered at the home of Mrs. Arthur Newman, and presented Miss Burley with a miscellaneous shower. She received many useful and beautiful gifts. A very pleasant evening was enjoyed by all.

DISTRICT 7

HOTEL DIEU HOSPITAL, KINGSTON: The graduating exercises of the St. Joseph Nursing School were held on September 24th, in St. Joseph's Hall in the presence of a large number of friends.

The hall was very attractively decorated with the school colours, blue and white.

There are eight nurses in the graduating class: Rev. Sister St. Margaret Mary (Mary Josephine O'Keefe), Marjorie Kathleen Larocque, Reine Marie Bergeron, Lucy Marie Driscoll, Irene Margaret Garvin, Mary Helena McDonald, Mary Elizabeth Speagle, and Evelyn Marie McGown.

The Very Rev. Monsignor J. F. Nicholson, Vicar General, was Chairman for the evening.

The presentation of diplomas to the graduates was made by Rev. Father J. G. Clancy and the Rev. Mother Superior presented the hospital pins.

Rev. Father G. Koster, C.S.S.R., of Brockville, addressed the graduates in a most eloquent and inspiring manner.

Following the graduating exercises a reception was held in the Nurses Home, where the graduates received the congratulations of their friends.

The Hotel Dieu Nurses Alumnae were hostesses at a well-arranged dinner at the La Salle Hotel in honour of the graduating class, and after dinner at a dance where the student nurses of both Hotel Dieu and the General Hospital were their guests.

The student nurses entertained the Graduating Class at a very delightful dance at the La Salle Hotel, the evening after graduation.

Dr. and Mrs. J. A. Hannan (Ruth Lyons), have arrived in Edinburgh, Scotland, where they plan to spend the next two years.

Miss Amy Ada (1926), has returned to Buffalo, N.Y., after spending some time with her parents in Kingston. Miss Ada has quite recovered from a serious illness.

DISTRICT 8

OTTAWA: Miss K. Pridmore (Lady Stanley Institute), has accepted a position in the office of Dr. S. Evans.

Miss Norma Lewis (St. Luke's Hospital), has accepted a position as resident nurse at Ashbury College.

CIVIC HOSPITAL, OTTAWA: Miss Elsie G. McIntyre (1927), of New Haven, Conn., has been visiting in town recently.

Miss Sybil Everitt (1927), with the Victorian Order of Nurses at Moncton, N.B., has also been holidaying in Ottawa.

Miss B. J. Rumsey has resigned as supervisor and is now residing in Newmarket, Ontario.

Miss B. V. Hughes has returned to duty in the Soldiers' Ward after a long absence through illness.

Misses M. Dale and M. R. Downey (1929), are relieving in the Hospital at present.

Miss Edna M. Brown (1928), is at present taking the Public Health Course in Toronto.

QUEBEC

ROYAL VICTORIA HOSPITAL, MONTREAL: Miss Hazel MacDonald (1927), is taking a post graduate course at the Phipp's Clinic, Baltimore.

Miss Hilda Foster (1926), is engaged in post graduate work at the Rockefeller Institute, New York.

The following have accepted positions in the Royal Victoria Hospital: Miss Catherine Dart (1929), in the Neuro-Surgical Research Department; Miss Rae Fellowes (1928), in charge of a floor in the Maternity Pavilion; Miss Beatrice Hewitt (1919), in charge of a floor in the Maternity Hospital.

Miss Marion Bradbury (1924), is seriously ill at her home in Heart's Content, Nfld.

Miss M. F. Hersey, superintendent of nurses, is spending several months in England, the guest of Miss Young, Stansted.

CHILDREN'S MEMORIAL HOSPITAL, MONTREAL: A very delightful bridge was given by Miss A. S. Kinder, Honorary President of the Alumnae, on October 18th, 1929, the proceeds to go to the Flora Madeline Shaw Memorial Fund.

At the last monthly meeting, Dr. L. J. Rhea addressed the Alumnae on "Anterior Poliomyelitis". The lecture was both interesting and instructive. A delightful social hour was spent at the close of the meeting.

SHERBROOKE: A joint meeting of the Eastern Townships Graduate Nurses' Association and the Sherbrooke Hospital Alumnae was held at the home of Mrs. Guy Bryant on November 7th in order to discuss an increase in fees for maternity cases.

The E.T.G.N.A. has accepted a room in the Mackinnon Memorial Building to hold their meetings, and to give teas, etc. The graduate nurses have purchased a magnificent grandfather clock to be placed in the room as a memorial to their beloved Mrs. Mackinnon.

Misses Morrisette, Messias and Sutton, have returned from a very enjoyable trip

to Jamaica (Miss Messias' home), and are again on duty.

Several of the recent graduates have received their R.N. and are now on the register, doing Private Duty Nursing.

Miss Lucy Drew has resigned her position as night supervisor, Sherbrooke Hospital, and is succeeded by Miss Galleys.

JEFFERY HALE'S HOSPITAL, QUEBEC: Miss Nellie McKie has accepted a position on the staff of the Emanuel Hospital, Portland, Ore.

Miss McCallum has accepted a position with Price Brothers at River Bend, P.Q.

Miss McHarg has returned from her vacation, which she spent visiting the Canadian West and California.

Miss Hannah Ford has accepted a position with the Canada Pulp and Paper Company at Three Rivers, P.Q.

The sympathy of the members of the Alumnae is extended to the Misses Richardson in the death of their mother.

SASKATCHEWAN

MOOSE JAW: The Schools of Nursing of the Providence and the Moose Jaw General Hospitals have arranged a combined lecture course for this year. Such a scheme has been under consideration for some time and at the September staff meeting a committee was appointed, which decided that four subjects would be tried, two to be given in the class-room at each hospital. So far the arrangement has proved satisfactory both to the doctors who lecture and to the schools. In all probability the plan shall include all subjects next year.

Miss Joan Moir (Providence Hospital), is in charge of the hospital at Southey, Sask.

Miss Stella Ryckman has gone to Seattle to take a course in X-Ray work.

CITY HOSPITAL, SASKATOON: At the last meeting of the Alumnae which was held at the Sanatorium, Dr. Banton gave an interesting talk on the care of tuberculosis. Tea was served later at the Nurses Home.

The first dance of the season was held at the Art Academy, on October 22nd. A large crowd attended and a very enjoyable evening was spent.

Mrs. J. Stevenson (Gertrude Wallace, 1925), of Calgary, Alberta, is visiting her parents here.

Miss Muriel Armitage (1928), of the Sanatorium staff, who has been ill for some time is convalescing at her home at Meota, Sask.

Miss Alice McGowan (1927), of Pilot Mound, Manitoba, has returned to the city and is doing special duty.

Miss Irene Baker (1927), has resigned from the staff of the City Hospital.

GREY NUNS' HOSPITAL, REGINA: A tea, also a sale of knitted wear and aprons was held by the Alumnae on September 25th. Mrs. McLean and Mrs. Trudelle presided at the tea table, and in spite of the unpleasant weather there was a good attendance.

On October 5th, a very successful sale of home cooking was held.

VICTORIAN ORDER OF NURSES

APPOINTMENTS

Miss Rhoda Campbell (Department of Public Health Nursing, University of Toronto) is to open the new district of Kirkland Lake.

Miss Edith Raillton, in charge of district of Barrie, succeeding Miss Mildred Thomas, who resigned.

Miss Laura Spearing (Brantford General Hospital), to staff in Border Cities.

Miss Anna McFarland (School for Graduate Nurses, McGill University), in charge of Huntville district, replacing Miss Alice Hunt, transferred to Toronto.

Miss Bessie Wilson (Department of Public Health Nursing, University of Toronto), to staff, Pembroke district, replacing Miss Bessie Sweeney, who resigned to be married.

Miss Viola McFaul to the staff in St. Catharine's.

Miss K. E. Beattie, in charge, district of Stratford, to replace Miss Marjorie Stevens, who has resigned to be married.

Miss B. W. McRoberts, of the Cornwall, staff has been granted leave of absence for three months.

Miss Jessie Durrell has been transferred to take charge of the district of Renfrew.

Miss Emma Elliott has returned to duty in Timmins after a leave of absence on account of illness.

C.A.M.N.S.

The Overseas Nursing Sisters Association of Canada was organised on July 8th, 1929, in Montreal, with Mrs. S. Ramsey elected president, and Miss Margaret Macdonald appointed honorary president.

The Association shall meet biennially, coinciding in time and place with the general meeting of the Canadian Nurses Association. Nurses eligible for membership are those who are members of local associations and who have served overseas and also all nursing sisters who served overseas, who are on, or who have been honourably discharged from His Majesty's Service.

The objects for which the nursing sisters have formed a national association are:

(1) To foster the spirit of Patriotism and love for our King and Country, and to promote National Peace.

(2) To promote a greater feeling of unity and friendship between all Nurses who have served overseas.

(3) To act as a body when occasions arise which call for united effort.

Address of secretary-treasurer is: Mrs. W. Petch, 396 Olivier Avenue, Westmount, P.Q.

WINNIPEG: A general meeting of the Nursing Sisters' Club was held in the Nurses Home of the General Hospital on November 1st, when the president, Miss M. McGilvray occupied the chair, and also gave a very interesting talk on the events of the I.C.N. Congress, with special reference to the entertainment of, and courtesies extended to the Nursing Sisters.

The proposed Constitution and By-laws for an Overseas Nursing Sisters' Association of Canada were discussed, exception was taken to the fact that Nursing Sisters having served in Canada only were not eligible for membership. The Club voted in favour of an amendment to the effect that any nurse who has worn the King's uniform shall be accepted. The local association is honoured by having as members, Mrs. Howard, who served in the North-West Canada Expedition, and Mrs. J. H. R. Bond, who won the coveted medal of the Egyptian Campaign. Mrs. Bond also served in the South African War, and is the originator of the present military veil in Canada.

A resolution was passed in favour of Nursing Sisters only being employed on the nursing staffs of the Department of Pensions and National Health, and the Civil Service of Canada. The Canadian Legion also submitted this matter as being the wish of the returned men.

Several sisters volunteered to assist in the Poppy Day Campaign. Items of local interest were discussed, after which a delightful tea was served, kindly provided by Miss M. McGilvray and Miss K. Ross. A vote of thanks was passed to Miss J. Grant, superintendent of nurses, for extending to the Club the use of the Nurses Home.

The nursing sisters and friends met for their eleventh Armistice Tea on November 9th in the Hudson's Bay dining room. Miss M. McGilvray, president of the Club, and Miss K. McLearn received the guests. Bouquets of roses and chrysanthemums centred the tea table at which Mrs. Gordon Cooper, Mrs. D. Moulden, Mrs. A. McLeod and Mrs. A. McKean presided.

The sympathy of the Club is extended to Miss Brighty, who has been confined for some months in the King Edward Memorial Hospital.

Miss M. M. Johnston has been in the General Hospital for a lengthy period, and is the able secretary of the Club this year too.

Miss A. Canning, who underwent an operation some time ago, is back on the nursing staff of the T. Eaton Company.

Mrs. R. V. Scott and Miss J. Roberts have been taken on the staff of the Deer Lodge Convalescent Hospital.

Miss E. F. Hudson, M.R.R.C., has severed her connection with the Manitoba Canteen Board, and is now with the Federal Department of Immigration.

BIRTHS, MARRIAGES, AND DEATHS

BIRTHS

BADKE—On October 4th, 1929, at Toronto, to Mr. and Mrs. George Badke (Esther Armbrust, St. Catharines General Hospital, 1922), a daughter (Eleanor Caroline).

BOSWELL—On September 29th, 1929, at Kitchener, to Mr. and Mrs. Edward C. Boswell, of Baden, Ont. (Phoebe Smith, Kingston General Hospital, 1928), a son (Walter Edward).

CRAM—On August 18th, 1929, at Ottawa, to Mr. and Mrs. Alex. Cram (Mabel Bonell, Lady Stanley Institute, Ottawa), a daughter.

CRAWFORD—On June 3rd, 1929, at Beirut, Syria, to Mr. and Mrs. Archie Crawford (Mary Pickard, Royal Victoria Hospital, Montreal, 1922), a son (John Pickard).

FALLON—On October 14th, 1929, at Kingston, to Mr. and Mrs. V. Fallon (Hotel Dieu, Kingston, 1919), a son (Francis Michael).

FYFE—Recently, at Regina, to Mr. and Mrs. Fyfe (Grey Nuns' Hospital, Regina, Sask.), a son.

GARNER—On August 13th, 1929, at Ottawa, to Mr. and Mrs. Chas. Gardner (Eleanor Ross, Ottawa Civic Hospital), a daughter.

GIBBARD—On September 16th, 1929, at Ottawa, to Mr. and Mrs. James Gibbard (Amy Gunn, Wellesley Hospital, Toronto, 1927), a son.

HALL—On September 3rd, 1929, at Toronto, to Mr. and Mrs. J. H. Hall (Marjorie M. Wilson, Grace Hospital, Toronto, 1917), a daughter (Vera Marion).

HAMMOND—On October 16th, 1929, at Toronto, to Mr. and Mrs. Jas. Hammond (Nora Gordon, 1926, Toronto General Hospital), a son.

KENNEDY—On October 16th, 1929, at Toronto, to Mr. and Mrs. T. A. Kennedy (Ruby Cameron, 1919, Toronto General Hospital), a daughter.

LEAMING—In June, 1929, to Mr. and Mrs. Charles Leaming (Pearl Beckett, Wellesley Hospital, Toronto, 1927), a son.

LUMSDEN—On October 8th, 1929, at Hamilton, to Mr. and Mrs. Hugh Lumsden (Ida May Latimer, Hamilton General Hospital, 1926), a daughter (Joyce Elizabeth).

MAHOOD—On October 22nd, 1929, at Ottawa, to Dr. and Mrs. A. E. Mahood (Hazel Johnston, Lady Stanley Institute, Ottawa), a son.

MANN—On August 19th, 1929, at Toronto, to Mr. and Mrs. Douglas Mann (E. Dorothy McWilliams, Grace Hospital, Toronto, 1917), a son (John).

MANSFIELD—On October 25th, 1929, at Ottawa, to Mr. and Mrs. Leland Mansfield (Catherine Paris, Toronto General Hospital), a son.

McCRIMMON—On October 1st, 1929, at Toronto, to Mr. and Mrs. Murray McCrimmon (Marion McLennan, 1922, Toronto General Hospital), a son.

MONTGOMERY—On October 17th, 1929, at Toronto, to Dr. and Mrs. R. C. Montgomery (Margaret Jackson, 1923, Toronto General Hospital), a son.

MOONEY—On October 23rd, 1929, at Gananoque, Ont., to Mr. and Mrs. F. Mooney (Mary E. Jewy, Hotel Dieu, Kingston, 1926), a daughter.

PENTECOST—On August 7th, 1929, at Toronto, to Dr. and Mrs. Reginald S. Pentecost (Jean Isobel Henry, Grace Hospital, Toronto, 1927), a daughter (Barbara Jean).

SMALL—On July 8th, 1929, at San Francisco, Cal., to Mr. and Mrs. Philip Small (Leonore Mitton, Royal Victoria Hospital, Montreal, 1920), a daughter (Elizabeth Anne).

WATERMAN—Recently, at Ottawa, to Mr. and Mrs. Waterman (Marjorie Clark, Jeffrey Hale's Hospital, Quebec), a daughter.

MARRIAGES

ARNOTT—BURLEY—On August 16th, 1929, at Belleville, Ont., Annie Laura Burley to Clarence Robert Arnott.

BRICELAND—McDONALD—Recently, at Wolfe Island, Ont., Myrtle Elizabeth McDonald (Hotel Dieu Hospital, Kingston, 1927), to W. L. Briceland, of Rochester, N.Y.

CARROLL—CARR—On September 14th, 1929, Anna Carr (Wellesley Hospital, Toronto, 1927), to William Carroll.

CARTER—TAIT—On July 13th, 1929, at Castleton, Ont., Jessie Marion Tait to Earl A. Carter, Cobyville, Ont.

CONNERY—LOWRY — On September 14th, 1929, at Pakenham, Ont., Dorothy M. Lowry (Ottawa Civic Hospital, 1927), to James Connery, Pakenham, Ont.

CROCHER—BATE—On September 3rd, 1929, at Newcastle, N.B., Alice Muriel Bate (Royal Victoria Hospital, Montreal, 1921), to Hubert LeRoy Crocher.

DEACOFF—THURLOW—On August 21st, 1929, at Schreiber, Ont., Helen Christine Thurlow (Grace Hospital, Toronto, 1927), to James McDonald Deacoff, Toronto.

DeBELLE—STEVENS—On July 20th, 1929, at Amherst, N.S., Hazel May Stevens (Royal Victoria Hospital, Montreal, 1928), to John Ernest DeBelle, M.D.

DIXON—CURRAN — On October 16th, 1929, at Toronto, Henrietta Curran (St. Catharines General Hospital, 1921), to James Dixon, Port Dalhousie, Ont.

DUNNING—YOUNG—On October 19th, 1929, at Ottawa, Mornington (Morna) C. Young (Ottawa Civic Hospital, 1926), to Dr. Gregory W. Dunning, Ottawa.

EDWARDS—DUNFIELD—On September 10th, 1929, at Ottawa, Marjorie Belle Dunfield (Lady Stanley Institute, 1924), to Reginald Edwards, Montreal.

ELLIOT — COMMERFORD — On October 2nd, 1929, at Montreal, Irene Commerford (Women's General Hospital, Montreal, 1925), to Jack Elliott. At home, Toronto, Ont.

ETHIER—TULLOCK—On August 29th, 1929, Eleanor Lilian Tullock, of Stirling, Ont., to Albert Edward Ethier, Belleville, Ont.

FINDLAND—DAVY—On September 6th, 1929, at Kingston, Audry Davy (Kingston General Hospital, 1928), to Hugh Findland.

GILLRIE—MAY—At Calgary, Alta., November 9th, 1929, Edna Beatrice May (Jeffrey Hale Hospital, Quebec, P.Q.), to William Walsindham Gillrie, of Calgary.

GRAHAM—CHASE—On September 17th, 1929, at Ottawa, Amy Chase (Ottawa Civic Hospital, 1927), to Cyril Graham, Ottawa.

HANNAN—LYONS—On September 3rd, 1929, at Kingston, Ruth Agnes Lyons (Kingston General Hospital, 1928), to Dr. Jason Albert Hannah.

McKENNA—WILSON—On October 5th, 1929, at Ottawa, Margaret L. Wilson (Ottawa Civic Hospital, 1926), to Arthur McKenna, Ottawa.

McLAUGHLIN—PALMER — On September 17th, 1929, at Ottawa, Marjorie Palmer (Ottawa Civic Hospital, 1927), to Wilfred McLaughlin, Toronto.

NATHANSON—TRUMAN — Recently, at New York, Kathleen Truman (Hamilton General Hospital, 1926), to Arnold Nathanson, New York.

OVEREND—HOBDEN—On October 7th, 1929, at Toronto, Reita R. Hobden (Hamilton General Hospital, 1921), to Harold J. Overend, Ph.D., Orillia, Ont.

PITT—THORPE — On September 4th, 1929, at Toronto, Florence Mae Thorpe (Grace Hospital, Toronto, 1926), to John Alfred Pitt, Dryden, Ont.

ROCKWELL—LYNDS — On July 16th, 1929, at Saint John, N.B., Margaret Estelle Lynds (Royal Victoria Hospital, Montreal, 1925), to William H. Rockwell.

SABITINI—WOODFORD — On February 7th, 1929, at New York, Eunice M. Woodford (Connaught Training School for Nurses, Toronto, 1919), to Dr. R. F. Sabitini, New York.

SLOAN—MERWIN—On September 11th, 1929, at Peterborough, Ont., Jean Merwin (Wellesley Hospital, Toronto, 1920), to Max Sloan.

TOVELL—BALLANTYNE—On July 6th, 1929, at Chicago, Ill., Lavina Ballantyne (Kingston General Hospital, 1926), to Dr. Ralph M. Tovell, Rochester, Minn.

WAGSTAFF—LEACH—On October 16th, 1929, at St. Catharines, Susan Leach (St. Catharines General Hospital, 1925), to James Wagstaff.

WARD—LOVELAND — In August, at Montreal, Ruth Loveland (Jeffery Hale's Hospital, Quebec, 1927), to Arthur Ward, Bury, P.Q.

WATTERSON—PEARSON — On September 17th, 1929, at Ottawa, Martha I. Pearson (Ottawa Civic Hospital, 1926), to M. E. Watterson, Kemptville, Ont.

WILL—RONSON—On October 19th, 1929, at Brantford, Ont., Thelma I. Ronson (Hamilton General Hospital, 1928), to Frank Will, Hamilton.

WILSON—PATERSON — On November 6th, 1929, at Ladner, B.C., Gertrude Paterson (Vancouver General Hospital, 1924), to Ross Wilson.

WHITLA—GRAHAM — On July 13th, 1929, at Edmonton, Alta., Olive Wisdom Graham (Royal Victoria Hospital, Montreal, 1923), to William H. Whitla.

WISEMAN—HIGGINSON — On September 28th, 1929, at Inkerman, Ont., Lillian Higginson (Kingston General Hospital, 1928), to Reginald Wiseman, Napanee, Ont.

DEATHS

HALPIN—On November 5th, 1929, suddenly, at her home in Wallaceburg, Ruth Halpin (Hamilton General Hospital, 1920).

MURPHY—On September 28th, 1929, in New York City, Vivian Murphy (Hotel Dieu Hospital, Kingston, 1918).

NOTICE

Reprints of *Survey of Nursing Education in Canada*, by Dr. G. M. Weir, Director of the Survey, are available at the National Office, Canadian Nurses Association, 511 Boyd Building, Winnipeg. Price 10 cents each, or 12 copies for $1.00.

Contributors to the News Notes Section are asked to kindly remember that such items should be received at the National Office by the 12th of each month.

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INDEX

Volume XXV. Year 1929

January	Pages 1- 56	May	Pages 225-228	September	Pages 449-594
February	" 57-112	June	" 281-336	October	" 595-650
March	" 113-168	July	" 337-392	November	" 651-706
April	" 169-224	August	" 393-448	December	" 707-762

BIOGRAPHICAL NOTES, ETC.:

Andersen, Petrea K. 236
Andrews, Mrs. Lancelet 236
Arntzen, Andrea 296
Becker, Kirsten 236
Bennie, Mrs. W. G. 238
Breay, Margaret 236
Browne, Jean E. 416
Brownsdon, Ellen 368
Chan, Agnes 235
Chaptal, Mlle. 294
Clayton, S. Lillian 238
Cox-Davies, Rachel 236
Eldredge, Adda 239
Feldthaus, Clara 235
Fenwick, Mrs. Bedford (with photograph) 117
Francis, Susan C. 239
Gage, Nina D. (with photograph) 117
Goodrich, Annie A. 234
Gordon, Ann S. 238
Grenier, M. 295
Guevara, Martina 235
Gunn, Jean I. (with photograph) 119
Guttormsen, Gunhild Marie 296
Hartley, Annie J. (with photograph) 132. 401
Healy, Nellie 237
Hellemans, Jeanne 294
Hervey, Antoinette 295
Horn, Frances 238
Horn, Maren 296
Hsun, Mr. Kuo Jung 235
Ingram, Ruth 235
de Joannis, Jeanne 295
Johns, Ethel (with photograph) 674
Larsson, Sister Bergljot 295
Llerena, Hortensiz Perez 235
Kehrer, Meta 236
Mitchell, Alexandra McD. 238
Musson, Ellen Mary (with photograph) 119
McKenny, Cecilia 237
Noyes, Clara D. (with photograph) 118
d'Ornellas, Mere Catherine 295
Pearse, Helen Lucy 236
Petersen, Cornelia 235
Platou, Harriett 296
Reimann, Christiane (with photograph) 120
Romanowska, J. 237
Russell, E. Kathleen (with photograph) 417
Serton, M. 237
Shi, Hsi En 234
Slater, Catherine Frances 237
Sorensen, Petrea 235
Strong, Mrs. Rebecca (with photograph) 296, 478
Suffczynska, Miss 237
Terpatra, A. 237
Tscherning, Mrs. Henny 234
Villiers, Susan A. 368
Wesseling, S. A. 237
Wu, Lillian 243

BOOK REVIEWS 21, 89, 145, 196, 250, 307, 376, 417, 630, 682, 734

DEPARTMENT OF NURSING EDUCATION:

Community Need in Relation to the Education of the Nurse — Marie Chaptal 544
Concerning Co-operation — S. Persis Darrach 676
Educational Development in the School of Nursing — Sister Jovita 721
Eliminating the Unfit from the School of Nursing — Elizabeth W. Odell 723
Exchange Scholarships — Alice Lloyd Still 509
Florence Nightingale's Birthday Was Kept in China, How — Gladys Stephenson 415
Gift to Nursing Education 675
Graduation — Dr. Gordon Jackson 356
History of Nursing Society, McGill University — Ursula Whitehead 246
McGill University School for Graduate Nurses 301
Mental Hygiene and Nursing — Dr. G. A. Davidson 243
Methods in Teaching Ethics — Charlotte Talley 352
Nursing Education in a University — Gertrude E. Hodgman 22
Organisation of Post-Graduate Study in Nursing — Rachel Cox-Davies 550
Preparation of a Curriculum, The — Dr. Stanley Ryerson 535
Staff Education — Eileen C. Flanagan and Kathleen B. Hill 241
State Supervision in Schools of Nursing — Adda Eldredge 545
Status of Nursing Among French Canadians 133
Summer Relief Nurses — Pearl L. Morrison 245
Teaching of Bacteriology, The — Ruth F. Walden 413
Training of a Public Health Nurse, The — E. Kathleen Russell 78
Training School Records in Smaller Hospitals — C.E.Guillod 298
Training School Problems — C. E. Guillod 187
Trends and Developments in Vocational Education — Dr. W. W. Charters 541
University Schools of Nursing — Annie W. Goodrich 512
Vocational Guidance — Grace M. Fairley 137

DEPARTMENT OF PRIVATE DUTY NURSING:

Ante-Operative and Post-Operative Care ... 191
Constipation: Its Cause and Correction ... Dr. N. A. Page 618
Constipation: Its Cause and Correction—Correspondence ... 725
Economics of Nursing, The ... Elizabeth Fox 576
Eczema ... Dr. Harold Orr 303
Emotional Development of the Pre-School Child, The ... S. Leslie Bell 25
Hourly Nursing ... Margaret L. Moag 138
Immunology and Prophylaxis ... Dr. W. T. Shirreff 418
Interpretation of Some Clinical Laboratory Studies ... Dr. A. G. McGhie 357
Interesting Case of Diphtheria, An ... Dr. F. S. MacPherson 248
Modern Developments in Private Nursing ... Isabel Macdonald 574
Most Interesting Case, My ... Maureen Carley 249
Nursing Care of Eczema (illustrated) ... Ethel English 305
Nursing of the Mentally Sick, The ... Claudia M. Fleming 83
Status and Problems of the Private Duty Nurse ... A. S. Gordon, Agnes Chan, Jessie Bicknell, E. C. Kaltcft and Janet Geister 572

DEPARTMENT OF PUBLIC HEALTH NURSING:

Co-Relating Health Education in a City Secondary School ... K. E. Dowler 624
County Health Unit—England ... Ruby M. Hamilton 678
Day with the Sisters of Charity in Zagreb, A ... Mary Millman 194
Developments in the Public Health Field ... Dr. G. B. Roatta 556
Fighting Diphtheria in New Brunswick ... Huilota Dykeman 143
Health Exhibition in Australia, A ... Elinor N. Wade 144
Home Nursing Training ... Anne Anderson Perry 366
Imperial Baby Week ... 255
Industrial Nursing ... K. S. Perrin 86
Mental Health: In the Home ... Isobel MacIntosh 364
In the Hospital ... Gertrude P. Garvin 362
In Industry ... Muriel Mackay 361
In the Nursery School ... Joyce Davidson 425
In the School ... Emma de V. Clarke 422
Mental Hygiene and Public Health ... Dr. S. R. Laycock 728
New Town Treatment Clinic ... M. E. Misner 30
Public Health Nurses' Bulletin ... 427
Public Health Nursing Programme ... Nan McMann 5
Red Cross Nursing Programme, The ... Mrs. Maynard Carter and Lucie Odier 562
Regional Conference—Victorian Order of Nurses ... 195
School Teacher's Health, The ... 626
Stowe House: An Open-Air School ... M. E. Misner 32
System of School Medical Inspection ... Dr. F. S. Burke 251, 307
Training Public Health Nurses ... Dr. H. W. Hill 29
True Story, A ... Contributed 628

EDITORIALS ... 401, 604, 660

ILLUSTRATIONS:

Board of Directors, I.C.N. ... 453
Breay, Margaret (photograph) ... 490
Chaptal, Mlle. (photograph) ... 464
Chateau Laurier, Ottawa ... 12
Clock Tower in Ordnance Yard, Halifax ... 184
Committee on Arrangements, Montreal ... 467
Exhibits ... 479-485
Farmer Smith's Camp for Crippled Children, Little Guests at ... 186
Federal Parliament Buildings at Night ... 9
Fenwick, Mrs. Bedford (photograph) ... 117
Gage, Nina D. (photograph) ... 117
Garden Party, McGill University Campus ... 459
General Session, International Congress of Nurses ... 455
Gunn, Jean I. (photograph) ... 119
Hartley, Annie J. (photograph) ... 132, 401
Hopital Notre Dame, Montreal ... 291
Hotel Dieu, Montreal ... 289
Japanese Luncheon ... 461
Johns, Ethel (photograph) ... 674
Letter Thanking Colony of Prince Edward Island for Red Cross Supplies to Crimea (facsimile) ... 240
Library, Winnipeg General Hospital ... 672
Members of Five New Countries Admitted to International Council of Nurses, 1929 ... 457
Memorial Chamber, Victory Tower, Ottawa ... 468
Montreal Art Gallery ... 193
Montreal General Hospital ... 287

Musson, Ellen Mary (photograph) 119
Noyes, Clara D. (photograph) 118
Old Fort at Annapolis Royal 185
Pauline, with deformed foot 172
Pauline, with foot straightened 172
Province House of Nova Scotia 183
Reimann, Christiane (photograph) 120
Roddick Memorial Gate, The 82
Roof Playground, War Memorial Hospital, London (illustration) 174
Royal Victoria Hospital, Montreal (photograph) 290
Russell, E. Kathleen (photograph) 417
Strong, Rebecca (photograph) 478
War Memorial Children's Hospital, London (illustration) 173

MISCELLANEOUS:

After the Congress, the Maritimes (illustrated) 183
Ante-Operative and Post-Operative Care 191
Breast Feeding in Health Centres (illustrated) Dr. A. B. Chandler 663
Call of Eternal Youth, The Mabel E. Finch 613
Canadian Council on Child Welfare—Annual Meeting, 1928 15
Canadian Tuberculosis Association, Scholarship Tour 17
Cancer Mortality, Reduction in 616
Care of Post-Poliomyelitis Patients Gladys E. Smiley 671
Care of the Premature Infant (illustrated) Edgeworth Murray 605
Challenge of the Future, The Florence H. M. Emory 227
Child Development Bird T. Baldwin 607
Child Welfare in New Zealand Olive M. Garrood 62
Citizen in Relation to the Public Health Programme, The Helen R. Y. Reid 597
Clinical Laboratory Studies, The Interpretation of Dr. A. G. McGhie 357
Community Need in Relation to the Education of the Nurse, The Marie Chaptal 544
Concerning Co-operation S. Persis Darrach 676
Congenital Atelectasis 296
Congress, 1929, The I.C.N. (illustrated) 451
Constipation: Its Cause and Correction Dr. N. A. Page 618
Co-Relating Health Education in a City Secondary School K. E. Dowler 624
Cost of Sickness, The Dr. J. L. Biggar 339
Cost of Hospital Service Dr. G. Harvey Agnew 181
County Health Units—United States of America Laura M. Gamble 718
Curriculum, The Preparation of a Dr. Stanley Ryerson 535
Day with the Sisters of Charity in Zagreb, A Mary Millman 194
Developments in the Public Health Field Dr. G. B. Roatta 556
Diet in Disease E. Laura Cody 411
Economics of Nursing, The Elizabeth Fox 576
Eczema Dr. Harold Orr 303
Eczema, Nursing Care of (illustrated) Ethel English 305
Education of the Crippled Child (illustrated) Ethel Teasdail 171
Education of the Nurse, Community Need in Relation to Marie Chaptal 544
Education and Service of the Nurse 612
Electric Shock, Treatment of P. Lumly 232
Emotional Development of the Pre-School Child, The S. Leslie Bell 25
Exchange Scholarships Alice Lloyd Still 509
Exhibits, I.C.N. Congress, 1929 (illustrated) 478
Florence Nightingale's Birthday Was Kept in China, How Gladys Stephenson 415
Future, The Adelaide Nutting 492
Future of Mental Nursing, The 399
Greeting to the Canadian Nurse, A Nina D. Gage 3
Health Centres, Breast Feeding in (illustrated) Dr. A. B. Chandler 663
Health Education in City Secondary Schools, Co-Relating K. E. Dowler 624
Health Examinations, Value of Periodic Dr. A. Grant Fleming 283
Health Preservation through Adequate Diet Sister Irene Marie 176
Hospitals of the Montreal Hospital Council (illustrated) 286
Hospital Service, Cost of Dr. G. Harvey Agnew 181
Housewives' Neurosis Mary Chadwick 230
Immigration, Medical Aspects of Dr. J. D. Page 395
Immunology and Prophylaxis Dr. W. T. Shirreff 418
Importance of the Social Life of the Student Nurse, The Beatrice Creasy 128
International Council of Nurses' Congress 115, 197, 256, 313, 368
International Council of Nurses: Aims Nina D. Gage 4
Biographies, Grand Council 294
Founders and Officers 116
Grand Council 234
International Council of Nurses 74

Interpretation of Some Clinical Laboratory Studies, The	Dr. A. G. McGhie	357
Jean Browne, Miss, in Geneva		416
Lazaretto at Tracadie, N.B., The	A Sister of St. Martha	348
League's Latest Enterprise, The	Jean E. Browne	10
Legislation in Nursing	E. M. Musson	552
Maritimes, The: After the Congress (illustrated)		183
Maternal Mortality with Questionnaire, National Council of Women		125
Medical Aseptic Technique	Ella M. Forrest	715
Medical Aspects of Immigration	Dr. J. D. Page	395
Mental Hygiene Movement in Canada, The	Dr. Chas. F. Martin	59
Mental Hygiene and Nursing	Dr. G. A. Davidson	243
Mental Nursing, The Future of		399
Mentally Sick, The Nursing of the	Claudia M. Fleming	83
Modern Developments in Private Nursing	Isabel Macdonald	574
National Council of Women—Maternal Mortality, with Questionnaire		125
Need for Publicity in Nursing, The	Gertrude Cowlin	522
Nervous Troubles of Children		407
New Brunswick Association of Registered Nurses	Gertrude Williams Jones and Emma J. Mitchell	18
Nurses' Bulletin, British Columbia		427
Nurse as a Citizen, The	Bertha Wellin	505
Nurse and the Law, The	Harold Fisher	70
Nurses' Library, Winnipeg General Hospital (illustrated)	Rachel N. Fogarty	672
Nursing of the Mentally Sick, The	Claudia M. Fleming	82
Occupational Therapy	Genevieve L. Hurd	13
Organisation of Post-Graduate Study in Nursing, The	Rachel Cox-Davies	550
Ottawa (illustrated)		8
Poliomyelitis		408
Poliomyelitis Epidemic, Report on, in Manitoba, 1928		297
Post-Poliomyelitis Patients, Care of	Gladys E. Smiley	671
Post-Graduate Study, The Organisation of	Rachel Cox-Davies	550
Preparation of a Curriculum, The	Dr. Stanley Ryerson	535
Premature Infant, Care of (illustrated)	Edgeworth Murray	605
Pre-School Child, The	Dr. G. A. Lamont	799
President's Address	Nina D. Gage	486
Professional Obligations, Our	Jean E. Browne	121
Progress and Opportunities in the Field of Nursing	A Student Nurse	130
Public Health Field, Developments in	Dr. G. B. Roatta	556
Public Health Nursing Programme	Nan McMann	5
Publicity in Nursing, The Need of	Gertrude Cowlin	522
Red Cross Nursing Programme, The	Mrs. Maynard Carter and Lucie Odier	562
Reduction in Cancer Mortality		616
Report on the Poliomyelitis Epidemic in Manitoba, 1928		297
Royal New Zealand Society for the Health of Women and Children	Aileen Partridge	64
Rural Nursing	Alexandra Wacker and Nikica Bovolini	527
Rural Nursing as Health Centres	Mary K. Nelson	530
Rural Nursing from the Viewpoint of the Public Health Nurse	Elizabeth Smellie	531
Scientific Method in Social and Health Work, The	Julius Tandler	498
Smallpox		351
Social Life of the Student Nurse, The Importance of	Beatrice Creasy	128
Social and Health Work, Scientific Methods in	Julius Tandler	498
State Supervision in Schools of Nursing	Adda Eldredge	545
Status and Problems of the Private Duty Nurse, The	A. S. Gordon, Agnes Chan, Jessie Bicknell, E. C. Kaltoft and Janet Geister	572
Survey of Nursing Education in Canada	Dr. George M. Weir	653
Treatment for Electric Shock	P. Lumly	232
Trends and Developments in Vocational Education	Dr. W. W. Charters	541
University Schools of Nursing	Annie W. Gooderich	512
Value of Periodic Health Examinations, The	Dr. A. Grant Fleming	283
Venereal Disease Clinic, The	Dr. Gordon Bates	402
Victorian Order Supervisors Demonstrate to McGill Students	M. L. Moag	433
Vocational Education, Trends and Developments in	Dr. W. W. Charters	541
Watchword, The—"Service"	Ethel G. Fenwick	490
NEWS NOTES	36, 92, 147, 202, 259, 315, 369, 428, 631, 684, 736	
OBITUARY: Maxwell, Anna C.		123
OFFICIAL DIRECTORY	45, 101, 155, 211, 267, 323, 379, 435, 581, 637, 691, 749	
REPORTS		
New Brunswick Association of Registered Nurses, Historical		18
Pol omyelitis Epidemic in Manitoba, 1928		297
Provincial Meetings, Annual Reports, British Columbia, Ontario and Saskatchewan		257

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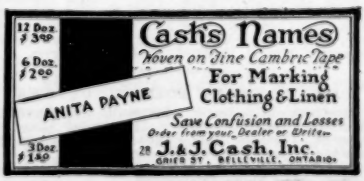

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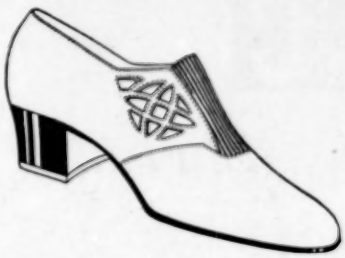

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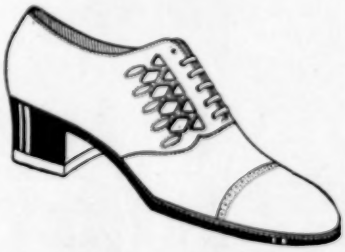

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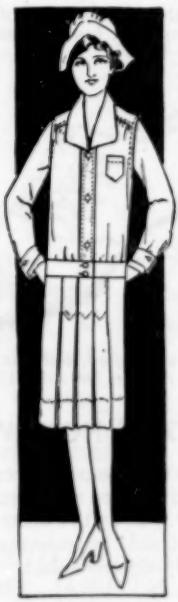

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